United States Court of Appeals
for the Second Circuit

APPENDIX

Vol. I

77-6152,74

JOINT APPENDIX, Volume I

In the

United States Court of Appeals

For the Second Circuit

No. 77-6152, 74

Vol. I

UNITED STATES COURT OF APPEALS
FILED
NOV 14 1977
A. DANIEL FUSARO, CLERK
SECOND CIRCUIT

Hospital Association of New York State, Inc., Misericordia Hospital Medical Center, Buffalo General Hospital, The Genesee Hospital, and The Mount Sinai Hospital on behalf of themselves and all other nonprofit hospitals which are members of the Hospital Association of New York State, Inc., and which are reimbursed for Medicaid Services rendered to hospital patients,

Plaintiffs-Appellants,

—v.—

Philip L. Toia, as Commissioner of Social Services of the State of New York, Robert P. Whalen, as Commissioner of Health of the State of New York, Peter Goldmark, as Director of the Budget of the State of New York, Hugh L. Carey, as Governor of the State of New York,

Defendants-Appellees,

—and—

F. David Mathews, as Secretary of the U. S. Department of Health, Education and Welfare,

Defendant.

BP/5

APPEAL FROM THE JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

PAGINATION AS IN ORIGINAL COPY

TABLE OF CONTENTS OF APPENDIX

Page

Relevant Docket Entries 1

New York State Plan Submittal 76-8 3

Appellants' Original Complaint. 6

New York State Plan Submittal 76-28 22

Appellees' Answer to Appellants' Original Complaint. 62

Transcript of Proceedings of July 15, 1976. 69

New York State Plan Submittal 76-41 89

Appellants' First Amended Complaint 92

Order to Show Cause 114

Affidavit of James C. Ingram 117

Affidavit of S. David Pomrinse 133

Affidavit of Irvin G. Wilmot 151

Affidavit of Darrell G. Hartline 158

Transcript of Proceedings of July 20, 1976 166

Affidavit of Seymour L. Budoff 260

Affidavit of William F. McCann 264

Appellees' Answer to First Amended Complaint. 280

Affidavit of James C. Ingram 288

Transcript of Proceedings of July 28, 1976 297

Oral Opinion of Judge Lasker of July 29, 1976 407

Judgment of the District Court dated July 29, 1976 (entered August 2, 1976). 428

New York State Plan Submittal 76-43. 432

Page

Appellees' Notice of Appeal of the August 2, 1976 Judgment to the Court of Appeals 435

Transcript of Proceedings of September 1, 1976. 437

Transcript of Proceedings of September 14, 1976. 457

Appellants' Second Amended Complaint. 481

Memorandum Opinion and Order of Judge Lasker on Stay of Judgment dated September 28, 1976 505

Transcript of Proceedings of September 28, 1976 511

Appellees' Answer to Second Amended Complaint 533

Order of Judge Lasker Staying Judgment of August 23, 1976. 542

Transcript of Proceedings of November 4, 1976 544

Memorandum Opinion and Order of Judge Lasker dated November 5, 1976 (entered November 9, 1976). 561

Correcting Memorandum of Judge Lasker dated November 11, 1976. 568

Endorsement of Judge Lasker dated November 16, 1976. 569

Appellees' Notice of Appeal of the November 9, 1976 Order to the Court of Appeals 570

Transcript of Proceedings of November 15, 1976 572

Appellees' Motion to Dismiss for Lack of Jurisdiction . . 577

Transcript of Proceedings of December 17, 1976 579

Affidavit of Jacob Imberman dated December 23, 1976, with exhibits 597

Endorsement and Order of Judge Lasker Denying Motion to Dismiss. 624

Transcript of Proceedings of February 3, 1977 626

Deposition of Seymour L. Budoff 630

Page

Opinion and Order of Remand of Court of Appeals dated March 16, 1977 631

Deposition of William McCann 635

Deposition of Robert P. Whalen 638

Transcript of Proceedings of April 21, 1977 640

Transcript of Proceedings of May 5, 1977 647

Transcript of Proceedings of July 21, 1977 680

Opinion of Judge Lasker Vacating Judgment dated August 4, 1977 684

Transcript of Proceedings of August 11, 1977 717

Order of Judge Lasker dated August 15, 1977, partially vacating August 2, 1976 judgment and ordering refund. 763

Appellants' Notice of Motion to Amend Order of August 15, 1977 765

Affidavit of Jacob Imberman in Support of Motion to Amend 767

Appellants' Notice of Appeal from Order of August 15, 1977 to Court of Appeals. 770

Transcript of Proceedings of September 14, 1977. 773

Endorsement and Order of Judge Lasker Amending Order of August 5, 1977, filed September 16, 1977 789

Appellees' Notice of Motion to Dismiss Complaint, and Memorandum 790

Amended Order partially vacating August 2, 1976 judgment and ordering refund, filed September 27, 1977. 816

Memorandum of Appellants in Opposition to Motion to Dismiss Complaint. 818

Page

Affidavit with exhibits and Memorandum of Health and Hospitals Corporation in Opposition to Motion to Dismiss Complaint. 832

Appellants' Notice of Appeal from Amended Order of September 27, 1977. 886

Endorsement and Order of Judge Lasker Dismissing Complaint dated October 13, 1977 888

Order of Judge Lasker dated October 14, 1977, that Order of October 13, 1977 be Entered as Judgment 891

Appellants Notice of Appeal to Court of Appeals from Judgment entered October 18, 1977 Upon Order of October 14, 1977 892

RELEVANT DOCKET ENTRIES

1976

May 5 -- Appellants' Original Complaint filed.
June 15 -- Appellees' Answer filed.
July 16 -- Appellants' Amended Complaint filed.
July 16 -- Appellants' Order to Show Cause for a preliminary injunction and Affidavits filed.
July 23 -- Affidavit of Seymour L. Budoff, Department of Health, Education and Welfare, filed.
July 26 -- Appellees filed Affidavit of William McCann in opposition to motion for preliminary injunction
July 26 -- Appellees' Answer to Amended Complaint filed.
July 28 -- Appellants' filed Affidavit of James C. Ingram.
July 30 -- Order and Opinion of Judge Lasker handed down.
August 2 -- Judgment for appellants by Judge Lasker entered.
August 4 -- Appellees' Notice of Appeal to the Court of Appeals filed.
August 31 -- Transcript of records of proceedings dated 7/15/76, 7/28/76, and 7/29/76 filed.
September 20 -- Appellants' Second Amended Complaint filed.
September 28 -- Order of Judge Lasker entered granting Appellees' Application for a Stay.
October 8 -- Appellees' Answer to Second Amended Complant filed.
October 29 -- Order of Judge Lasker regarding stay of judgment filed.
November 9 -- Memorandum Opinion and Order of Judge Lasker regarding retroactivity filed.
November 16 -- Transcripts of records of proceedings dated 7/20/76, 9/1/76, 9/14/76, 9/28/76 filed.
November 19 -- Appellees' Notice of Appeal to the Court of Appeals filed.
December 7 -- Appellees' motion to dismiss filed.
December 27 -- Affidavit of Jacob Imberman in opposition to motion to dismiss filed.

1977

January 26 -- Order of Judge Lasker denying appellees' motion to dismiss filed.

February 8 -- Filed transcripts of proceedings dated 11/15/76 and 12/17/76.

April 11 -- Filed order of Court of Appeals regarding Pub. L. No. 94-552.

May 23 -- Filed transcript of proceedings dated April 21, 1977.

July 12 -- Filed transcript of proceedings dated May 5, 1977.

August 5 -- Filed opinion of Judge Lasker dismissing claim for monetary relief.

August 15 -- Filed order of Judge Lasker dismissing claim for monetary relief.

August 23 -- Filed appellants' affidavit and notice of motion to amend order.

September 16 -- Filed endorsement and order of Judge Lasker amending order.

September 27 -- Filed amended order of Judge Lasker.

September 27 -- Appellees' notice of motion to dismiss and memorandum filed.

September 28 -- Depositions of William McCann and Robert P. Whalen filed.

September 28 -- Appellants' memorandum in opposition to motion to dismiss filed.

September 29 -- Health and Hospitals Corporation's memorandum and affidavit in opposition to motion to dismiss filed.

October 5 -- Transcripts of proceedings dated 2/3/77, 8/11/77 amd 9/14/77 filed.

October 13 -- Deposition of Seymour L. Budoff filed.

October 13 -- Appellants' amended notice of appeal filed.

October 14 -- Endorsement and order of Judge Lasker dismissing complaint filed.

October 17 -- Order of Judge Lasker that judgment be entered filed.

October 20 -- Appellants' notice of appeal from judgment dismissing complaint filed.

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12243

PHILIP L. TOIA
EXECUTIVE DEPUTY
COMMISSIONER

March 31, 1976

Dear Bill:

Enclosed is the State Plan amendment demanded by you under penalty of fiscal sanctions in your Action Transmittal, SRS-AT-76-14(MSA) dated January 28, 1976. This submission is designed to facially comply with the requirements of Section 111, P.L. 94-182, December 31, 1975.

Please be advised, however, that there are serious questions being raised by this and other states as to the constitutionality of the requirements imposed by this statute. Accordingly, this submission should not be interpreted as an acquiescence by us of the legal appropriateness of this demand. Indeed, we expect such questions to be resolved in an appropriate legal forum in the near future.

Sincerely,

Phil

Philip L. Toia

Honorable William Toby
Acting Regional Commissioner
Social & Rehabilitation Service
Region II
Department of HEW
Federal Building
26 Federal Plaza
New York, New York 10007

PARTMENT OF HEALTH, EDUCATION, AND WELFARE
CIAL AND REHABILITATION SERVICE
ington, D. C. 20201

Submit 6 Copies

1976

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION NY

TRANSMITTAL NUMBER: 76-8

STATE: New York

PROGRAM IDENTIFICATION: XIX

OF PLAN MATERIAL (CHECK ONE)

NEW STATE PLAN
AMENDMENT TO BE CONSIDERED AS NEW PLAN
AMENDMENT

PROPOSED EFFECTIVE DATE: January 1, 1976

LETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

RAL REGULATION CITATION

P.L. 94-182, Section 111

ER OF THE PLAN SECTION OR ATTACHMENT

Revised page 24a-Title XIX Plan
as required by SRS-AT-76-14

NUMBER OF THE SUPERSEDED PLAN SECTION O
ATTACHMENT

Page 24a

BJECT OF AMENDMENT

State Consent to Suit

VERNOR'S REVIEW (CHECK ONE)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

GNATURE OF STATE AGENCY OFFICIAL

PED
E: for Stephen Berger

TLE: Commissioner

TE: March 30, 1976

TURN TO:

NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 1 APR 1976

DATE APPROVED: MAY 1976

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

William Toby

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: William Toby

TITLE: Acting Regional Commissioner

REMARKS

Revision: SRS-AT-76-14(MSA)
January 28, 1976

State NEW YORK

Citation
45 CFR
250.70
F.R. 40-36

4.27 Disclosure of Information on Providers of Health Care Services and Contractors.

The State agency has established procedures for disclosure of information on providers of services, contractors, carriers, intermediaries and State agencies. These procedures meet all requirements of 45 CFR 250.70.

P.L. 94-182
Sec. 111

4.28 State Consent to Suit

The State hereby consents to allow suit in Federal court by or on behalf of providers of inpatient hospital services with respect to payment of reasonable costs of such services, furnished for any period after June 30, 1975, pursuant to section 1902(a)(13)(D) of the Act. The State waives any immunity from such a suit under the eleventh amendment to the Constitution or otherwise.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

5/5/76

---------------------------------------x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, and BUFFALO GENERAL HOSPITAL, on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

---------------------------------------x

76 Civ. 2027

CLASS ACTION COMPLAINT

Lasker

Plaintiffs, by their attorneys Proskauer Rose Goetz & Mendelsohn, for their complaint respectfully allege:

PRELIMINARY STATEMENT

1. This is a Class action for preliminary and permanent injunctive relief and a declaratory judgment brought by the Hospital Association of New York State, Inc., ("HANYS"), Misericordia Hospital Medical Center ("Misericordia") located in New York City and Buffalo General Hospital ("Buffalo"), located in Buffalo, New York, on behalf of themselves and the Association's members which are non-profit hospitals in New York State rendering services on

and after January 1, 1976 to patients under the joint federal and state medical assistance program provided for under Title XIX of the Social Security Act, 42 USC § 1396 et seq. ("Medicaid Program"). These hospitals comprise the Class herein. Since January 1, 1976 defendants Philip L. Toia, Robert P. Whalen, Peter Goldmark and Hugh L. Carey ("State Defendants") have imposed and continue to impose a freeze on reimbursement rates for hospital services rendered to patients by members of the Class under the New York State Medicaid Program. Under the freeze, hospitals are reimbursed for 1976 services at 1975 rates. The 1975 rates represented reimbursement for the reasonable costs of providing hospital services in 1975 and are less than the reasonable costs of providing hospital services in 1976.

2. By imposing this freeze, the State Defendants have violated and continue to violate Title XIX of the Social Security Act ("Medicaid Act") and regulations, article VI of the United States Constitution, the fourteenth amendment to the United States Constitution, the New York State Constitution and the New York State Social Services Law. Defendant Matthews is in violation of the Medicaid Act and regulations and the fifth amendment to the United States Constitution by failing to compel the State Defendants to comply with the Medicaid Act and regulations.

3. The effect of this freeze is that the members of the Class are being paid less than the reasonable cost of hospital services which they render Medicaid patients. The resulting illegal deprivation of sorely needed revenue threatens the hospitals' financial viability and, conse-

quently, their continued ability to provide high quality health care to the low income and indigent residents of New York State.

COUNT I

PLAINTIFFS

4. Plaintiff HANYS is a New York not-for-profit corporation having its principal place of business at 15 Computer Drive West, Albany, New York and is organized for the purpose of providing administrative and legal assistance to nonprofit hospitals in New York State.

5. Plaintiff Misericordia is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its principal place of business is in New York City, New York.

6. Plaintiff Buffalo is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its place of business is in Buffalo, New York.

DEFENDANTS

7. Defendant Philip L. Toia or his predecessor in office is, and at all times relevant hereto was, the Commissioner or Executive Deputy Commissioner of Social Services of the State of New York ("Commissioner of Social Services"). The New York State Department of Social Services is the single state agency designated to administer or supervise the administration of the medical assistance program under

the Medicaid provisions of the Social Security Act. In implementing the freeze, defendant Toia has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

8. Defendant Robert P. Whalen is, and at all times relevant hereto was, the Commissioner of Health of the State of New York ("Commissioner of Health"). In implementing the freeze, defendant Whalen has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

9. Defendant Peter Goldmark is, and at all times relevant hereto was, the Director of the Budget of the State of New York ("Director"). In implementing the freeze, defendant Goldmark has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

10. Defendant Hugh L. Carey is, and at all times relevant hereto was, the Governor of the State of New York ("Governor") and as such vested with the executive power of the State. In implementing the freeze, defendant Carey has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

11. Defendant David Matthews is, and at all times relevant hereto was, the Secretary of the United States Department of Health, Education and Welfare ("Secretary") and is the federal officer ultimately responsible for the lawful administration of the Medicaid Program.

JURISDICTION AND VENUE

12. This action arises under the Medicaid Act, 42 USC § 1396 et seq. and the regulations promulgated thereunder, 42 USC § 1983, the Administrative Procedure Act, 5 USC § 701 et seq., article VI of the United States Constitution, the the fifth and fourteenth amendments to the United States Constitution, the New York State Constitution, the New York State Public Health Law and the New York State Social Services Law.

13. Jurisdiction is vested in this Court under 28 USC §§ 1331, 1343, 1361, 2201 and 2202, Pub. L. No. 94-182, § 111 (Dec. 31, 1975), 89 Stat. 1054 and principles of pendent jurisdiction. The amount in controversy exceeds the sum of $10,000 exclusive of interest and costs.

14. Venue lies in this District pursuant to 28 USC § 1391.

CLASS ACTION ALLEGATIONS

15. Plaintiffs are authorized to and do bring this action pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure on behalf of themselves and all other nonprofit hospitals in New York State rendering hospital services to Medicaid patients on and after January 1, 1976. The Class is so numerous that joinder of all members is impractical. Upon information and belief, there are approximately 275 hospitals in the Class. There are questions of law and fact common to the Class, including whether the freeze on 1976 Medicaid hospital reimbursement rates is in violation of the Medicaid Act and regulations, the supremacy

clause (article VI of the United States Constitution), the fifth and fourteenth amendments to the United States Constitution, the New York State Constitution, and the New York State Social Services Law. Plaintiffs will fairly and adequately protect the interests of the Class. Defendants have acted and have refused to act on grounds generally applicable to the Class, thereby making appropriate preliminary and final injunctive and declaratory relief with respect to the Class as a whole.

STATEMENT OF FACTS

16. The United States provides funds to a state which is funding and administering a state plan approved by the Secretary for the provision of medical assistance to certain categories of low income and indigent persons in accordance with law. This joint federal-state program is known as the Medicaid Program, and is governed by Title XIX of the Social Security Act, 42 USC § 1396 _et_ _seq_., and the regulations promulgated thereunder.

17. The Medicaid Act and regulations require that a state Medicaid plan provide for payment to hospitals of the reasonable cost of in-patient hospital services rendered to Medicaid patients in accordance with methods and standards developed by the state and approved in advance of implementation by the Secretary. Pursuant to the Medicaid Act and regulations, changes cannot be made in the methods or standards for determining in-patient hospital reimbursement rates without the prior approval of the Secretary. The Medicaid Regulations, 45 C.F.R. § 250.30, provide that the reasonable cost of in-patient hospital services shall be determined in accordance with the standards and principles for ascertain-

ing reasonable cost under the Medicare Act, 42 USC § 1395 et seq. (with an exception not relevant hereto) or under an alternate method which has been approved in advance by the Secretary."

18. One of the criteria which the Medicaid regulations require the Secretary to consider before he approves an alternate method for the determination of reasonable cost is that the alternate method give "[a]ssurance of adequate participation of hospitals and availability of hospitals services of high quality to title XIX [Medicaid] recipients." 45 C.F.R. § 250.30(a)(2)(ii)(d).

19. The New York State Department of Social Services prepared the New York State Plan for Medical Assistance ("The Plan") which has been approved by the Secretary.

20. Under the Plan, the Commissioner has agreed that

> "As a condition for receipt of Federal funds under title XIX of the Social Security Act, the NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES...agrees to administer the program in accordance with the provisions of...[the] State plan, the requirements of title XIX of the Act, and all applicable Federal regulations and other official issuances of the Department." Preface to Section 1.

21. On March 30, 1976 the Commissioner executed an amendment to the Plan pursuant to Pub. L. No. 94-182, § 111 (Dec. 31, 1975), 89 Stat. 1054 consenting to suits in federal court by or on behalf of providers of in-patient hospital services with respect to payment of reasonable costs of such services and waiving any immunity from such

suits under the eleventh amendment to the Constitution or otherwise.

22. Pursuant to the Medicaid Act and regulations, the Plan includes in-patient hospital services among the services which will be provided to eligible Medicaid patients.

23. The Plan sets forth "the methods and standards used, after review and approval, for the payment of the reasonable cost of inpatient hospital services." Section 4.19(b). These methods and standards have been approved by the Secretary as an alternate method of reimbursement.

24. Under this alternate method, final rates are calculated in advance of the year to which they apply by adjusting allowable hospital costs incurred two years before the rate year to account for projected inflationary increases prior to and during the rate year. Projections of these increases are made on the basis of cost indicators such as the consumer and wholesale price indices.

25. The Medicaid hospital in-patient reimbursement rates for services rendered by members of the Class on and after January 1, 1976 were not calculated in accordance with this method. Instead, the members of the Class have been and continue to be reimbursed for 1976 services at 1975 rates which were calculated on the basis of projected increases in 1973 costs.

26. The rates received by the members of the Class in 1976 are interim rates and not final rates as is required under the approved alternate method.

27. As a result of the inflation to which the entire economy has been subject, the reasonable cost to the members of the Class for the delivery of in-patient hospital services to Medicaid patients has been and is greater in 1976 than it was in 1975. Thus, using 1975 rates as the rates for reimbursing the members of the Class for providing in-patient hospital services in 1976 necessarily results in the hospitals' receiving less than their reasonable costs.

28. The freezing of 1976 Medicaid in-patient hospital reimbursement rates at 1975 levels has never been approved by the Secretary.

29. The Medicaid Regulations, 45 C.F.R. § 246.10 (a)(3), require that an approved state plan provide for a medical care advisory committee which "will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency." The New York State Plan provides for a Medical Advisory Committee in accordance with 45 C.F.R. § 246.10. Section 365-c(2) of the New York State Social Services Law provides that the Medical Advisory Committee "shall advise the commissioner [of Social Services] with respect to [Medicaid] health and medical care services" and requires that the Committee meet at least once a year. The Medical Advisory Committee has not met within the past year and was not consulted about the implementation of the Medicaid in-patient hospital reimbursement rate freeze.

30. The New York State Public Health Law requires hospitals in New York State to provide certain in-patient hospital services. Pursuant to this statute, the members of the Class are obligated to provide in-patient hospital services to Medicaid-eligible patients. Under the freeze on 1976 rates for these services, the members of the Class will be reimbursed at less than reasonble cost for these services.

31. Pursuant to the Medicaid Act and regulations, and the New York State Plan, in-patient hospital services are supposed to be made available under the Medicaid Program to all Medicaid-eligible patients. If the freeze on 1976 Medicaid in-patient hospital reimbursement rates continues, many of these patients will be unable to obtain in-patient hospital care because of the financial impact of the freeze on the members of the Class.

STATUTORY CLAIMS

32. The freeze on 1976 Medicaid in-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan in that it results in the members of the Class being reimbursed at less than their reasonable cost for in-patient hospital services rendered to Medicaid patients.

33. The State Defendants have violated and continue to violate the Medicaid Act and regulations and the New York State Plan by formulating and applying 1976 Medicaid in-patient hospital reimbursement rates that were not calculated in accordance with the alternate reimbursement method contained in the Plan and approved by the Secretary.

34. The freeze on 1976 Medicaid in-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan in that it has not been approved as part of the New York Plan by the Secretary.

35. The failure of the State Defendants to formulate anything but interim 1976 Medicaid in-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan which require the issuance of final rates prior to the beginning of the rate year.

36. The freeze on the 1976 Medicaid in-patient hospital reimbursement rates violates the Medicaid Act and regulations, the New York State Plan and the New York State Social Services Law in that it was put into effect without proper prior consultation with the Medical Advisory Committee.

37. The freeze on the 1976 Medicaid in-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan since under it the availability of these services to Medicaid-eligible patients will be reduced below legally required levels.

CONSTITUTIONAL CLAIMS

38. The freeze on 1976 Medicaid in-patient hospital reimbursement has the effect of state law and violates the supremacy clause of the United States Constitution, article VI, because it is in conflict with the laws of the United States on the same subject matter.

39. The freeze on 1976 Medicaid in-patient hospital reimbursement rates violates the due process clauses

of the fifth and fourteenth amendments to the United States Constitution and the New York State Constitution insofar as the members of the Class are deprived of their property without due process of law when they are required to provide Medicaid patients with in-patient hospital care for which they receive reimbursement at levels less than reasonable cost.

40. Plaintiffs have no adequate remedy at law.

41. Plaintiffs have suffered and will continue to suffer irreparable injury unless the freeze on 1976 Medicaid in-patient hospital reimbursement rates is preliminarily and permanently enjoined.

COUNT II

42. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1-41 with the same force and effect as if fully set forth herein.

43. By Chapter 76 of the Laws of 1976 of the State of New York, adopted March 30, 1976, the members of the Class' Medicaid reimbursement rates for out-patient hospital services rendered during the period January 1, 1976 through March 31, 1977 have been frozen at the level of their 1975 out-patient rates.

44. The 1975 Medicaid rates for out-patient hospital services were calculated in advance of 1975 on the basis of 1973 allowable costs for such services which were then adjusted to account for inflationary cost increases expected to occur prior to and during 1975. The reasonable

cost to each of the members of the Class for the delivery of out-patient hospital services to Medicaid patients is greater in 1976 than it was in 1975 and is less than the maximum rate allowed under the Medicaid Act and regulations, namely, the reasonable customary charge. Thus, using 1975 rates as the rates for reimbursing 1976 out-patient hospital services necessarily results in the hospitals receiving less than their reasonable costs.

45. Pursuant to the Medicaid Act and regulations, and the New York State Plan, out-patient hospital services are supposed to be made available under the Medicaid Program to all Medicaid-eligible patients.

46. If the freeze on 1976 Medicaid out-patient hospital reimbursement rates continues, many of these patients will be unable to obtain out-patient hospital care because of the financial impact of the freeze on the members of the Class.

47. Under the Medicaid regulations, 45 C.F.R. § 250.30(a)(6), a state plan must provide for rates

> "which are designed to enlist participation of a sufficient number of providers of services in the [Medicaid] program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population."

At present, the out-patient departments of the members of the Class are the only source of the medical care and services provided for in the New York State Plan for a substantial number of persons eligible for Medicaid. If the freeze on 1976 Medicaid out-patient hospital reimbursement rates continues, many of these patients will be unable to obtain these services from members of the Class with the result that these services will not be available to these patients to the extent they are available to the general population.

48. The New York State Public Health Law requires hospitals in New York State to provide certain out-patient hospital services to persons in need thereof. Pursuant to this statute, the members of the Class are obligated to provide certain out-patient hospital services to Medicaid-eligible patients. Under the freeze on 1976 rates for these services, the members of the Class will be reimbursed at less than reasonable cost for these services.

CLAIMS

49. The freeze on the 1976 Medicaid out-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan since under it the availability of these services to Medicaid-eligible patients will be reduced below legally required levels.

50. The freeze on 1976 Medicaid out-patient hospital reimbursement rates has the effect of state law and violates the supremacy clause of the United States Constitution, article VI, because it is in conflict with the laws of the United States on the same subject matter.

51. The freeze on 1976 Medicaid out-patient hospital reimbursement rates violates the due process clauses of the fifth and fourteenth amendments to the United States Constitution and the New York State Constitution insofar as the members of the Class are deprived of their property with-

out due process of law when they are required to provide Medicaid patients with hospital care for which they receive reimbursement at levels less than reasonable cost.

52. Plaintiffs have no adequate remedy at law.

53. Plaintiffs have suffered and will continue to suffer irreparable injury unless the freeze on 1976 Medicaid out-patient hospital reimbursement rates is preliminarily and permanently enjoined.

WHEREFORE, plaintiffs pray

(a) that this Court declare and adjudge that the freeze on hospital reimbursement rates for services rendered Medicaid patients on or after January 1, 1976 be declared and adjudged unlawful;

(b) that this Court preliminarily and permanently enjoin the State Defendants and their successors, officers, agents, servants, employees and attorneys from applying or attempting to apply such freeze to the Class;

(c) that this Court preliminarily and permanently enjoin the State Defendants from submitting any amendment to the New York State Medicaid Plan which would authorize reimbursement for hospital services rendered Medicaid patients at less than reasonable cost;

(d) that this Court preliminarily and permanently enjoin defendant Matthews and his successors, officers, agents, servants, employees and attorneys from approving any amendment to the New York State Medicaid Plan which would provide for the reimbursement of hospital services rendered to Medicaid patients at less than reasonable cost;

(e) that this Court preliminarily and permanently order defendant Matthews to exercise such authority as is provided by law to compel compliance by the State Defendants with the Medicaid Act and regulations;

(f) that this Court issue an injunction which would preliminarily and permanently order the State Defendants, their successors, agents, servants, employees and attorneys to comply with all federal laws and rules and regulations of the United States Department of Health, Education and Welfare applicable to the New York Medicaid Program including reimbursement on the basis of reasonable cost so long as the State of New York continues to participate in the federal Medicaid Program; and

(g) that plaintiffs be awarded such other and further relief as to this Court may seem just and proper.

Dated: New York, New York
May 5, 1976

PROSKAUER ROSE GOETZ & ENDELSOHN

By /s/ Jacob Imberman
Jacob Imberman
A Member of the Firm
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022
(212) 593-9000

☆ U.S. GOVERNMENT PRINTING OFFICE –

EPA MENT OF HEALTH, EDUCATION, AND WELFARE
OC ND REHABILITATION SERVICE
, D. C. 20201

Submit 6 Copies

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

: REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION II

TRANSMITTAL NUMBER: 76-28

STATE: New York

PROGRAM IDENTIFICATION: XIX

PE OF PLAN MATERIAL (CHECK ONE)

☐ NEW STATE PLAN
☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
☐ AMENDMENT

PROPOSED EFFECTIVE DATE: May 28, 1976

MPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

DERAL REGULATION CITATION
45 CFR 250.30

MBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19A

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 4.19A filed under Submittal #76-1

JECT OF AMENDMENT

Part 86 - Commission Health's Administrative Rules and Regulations -
Reporting and Rate Certification for Medicaid Facilities

ERNOR'S REVIEW (CHECK ONE)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

NATURE OF STATE AGENCY OFFICIAL

ED
E Philip L. Toia

LE: Acting Commissioner

E June 3, 1976

: NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 8 JUN 1976

DATE APPROVED: 8/16/76

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: William Toby

TITLE: Acting Regional Commissioner

REMARKS

ATE OF NEW YORK
EPARTMENT OF SOCIAL SERVICES

WESTERN AVENUE • ALBANY 12243

EPHEN BERGER
[illegible]

August 13, 1976

Mr. Seymour Budoff
Social Rehabilitation Service
Department of Health, Education
and Welfare
26 Federal Plaza
New York, New York 10007

Re: Submittal 76-28

Dear Sy:

Pursuant to our discussion on August 12, 1976, enclosed please find the following clarification materials for the above submittal:

1. A revised copy of Submittal 76-28 which contains the clarifications submitted to you by letters dated August 5, 1976, August 9, 1976 and August 12, 1976.

2. A statement setting out the appeals process for hospitals. As indicated at our August 12th meeting, this process will be distributed to all hospitals statewide with sufficient detail to make it clear and readily accessible to all interested parties. Such distribution will incorporate both the enclosed and the process associated with 86.17-g and will take place as soon as is administratively possible.

As agreed, the enclosed should make it possible for you to approve Submittal 76-28, effective this date. Thank you for your efforts and those of your staff, on our behalf.

Sincerely yours,

Ray

J. Raymond Diehl, Jr.
Acting Deputy Commissioner
Division of Medical Assistance

Enc.

TITLE XIX PLAN

Submittal 76-28

As revised through August 13, 1976

Sec.
86.1 Definition
86.2 Medical facility rates; article IX-C corporations
86.3 Financial and statistical data required
86.4 Uniform system of accounting and reporting
86.5 Generally accepted accounting principles
86.6 Accountant's certification
86.7 Certification by operator or officer
86.8 Audits
86.9 Patient days
86.10 Effective period of reimbursement rates
86.11 Computation of basic rate
86.12 Payment for referred ambulatory services
86.13 Groupings
86.14 Ceilings on payments
86.15 Adjustments to basic computed rate
86.16 Final rates
86.17 Revisions in certified rates

Sec.
86.18 Rates for servic
86.19 Rates for medical fac ities without adequ cost experience
86.20 Less expensive altern atives
86.21 Allowable costs
86.22 Recoveries of expense
86.23 Depreciation
86.24 Interest
86.25 Research
86.26 Educational activitie
86.27 Compensation of opera and relatives of operators
86.28 Costs of related orga izations
86.29 Return on investment
86.30 Capital cost reimburs ment
86.31 Termination of servic
86.32 Sales, leases and rea transactions
86.33 Reserved *
86.34 Interim Rules for Residential Health Care Facilities

*See note attached

Section 86.1 Definition. As used in this Part, the term "medical facility" shall be deemed to include all facilities or organizations covered by the term " hospital or home health agencies" as defined in rticle 28 of the Public Health Law, except residential health care facilities provided that such medical facility possesses a valid operating certificate issued by the State Commissioner of Health and where required, has been established by the Public Health Council.

86.2 Medical facility rates; article IX-C corporations. (a) Computation of rates of payment by article IX-C corporations to medical facilities shall be governed by the provisions of this Part.

(b) Each such corporation shall submit, for approval by the State Commissioner of Health, a proposed reimbursement formula not inconsistent with the rules set forth in this Part.

(c) Any such corporation or combination of corporations may, upon application to and approval of the State Commissioner of Health, use a different grouping of facilities for reimbursement computation purposes, provided such grouping assures incentive for the efficient operation of individual medical facilities equal to those under the groupings provided for in section 86.13 of this Part.

(d) The State Commissioner of Health may not certify rate schedules for payments by such corporations unless they have submitted to the commissioner and received approval of a plan which:

(1) establishes a procedure for monitoring the need for hospital admissions of its subscribers; and

(2) establishes a procedure for the re-certification of a subscriber's continued hospital service needs.

86.3 Financial and statistical data required. (a) Each medical facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (medicare) shall use the same fiscal year for title XIX (medicaid) and title V (children's bureau programs) as is used for title XVIII. All medical facilities must report their operations from January 1, 1977 forward on a calendar year basis.

(b) Financial and statistical reports required by this Part shall be submitted to the department and/or its agent no later than 120 days following the close of the fiscal period. Extensions of time for filing reports may be granted upon application received at least 15 days prior to the due date of the report and only in those circumstances where the medical facility establishes, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a medical facility fails to file the required financial and statistical report on or before the due dates, or as the same may be extended pursuant to paragraph (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

86.4 Uniform system of accounting and reporting. Medical facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by the various types of medical facilities in accordance with the appropriate section of the State Hospital Code covering the particular type of facility. Rate schedules shall not be certified by the Commissioner of Health unless medical facilities are in full compliance with reporting requirements of these sections.

86.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility unless the reporting instructions authorize specific variation in such principles.

86.6 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to medical facilities operated by units of government of the State of New York.

86.7 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

86.8 Audits. (a) All fiscal and statistical records and reports shall be subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the records of medical facilities, when appropriate, and in a time and manner to be determin by the State Department of Health. Where feasible, the department sh enter into an agreement to use a combined audit (medicare-medicaid an other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs.

(c) The required fiscal and statistical reports shall be subject audit for a period of six years from the date of their filing with the department. This limitation shall not apply to situations in whic fraud may be involved.

(d) Medical facilities shall be given 30 days after the mailing of notification of audit findings to appeal such findings by submitting data intended to justify the facility's position in the areas of disagreement. Failure by the medical facility to reply to such findings within the 30 day period, or to receive from the department an extension of time for reply, shall be considered as acceptance of the findings.

(e) Rate revisions resulting from audit findings may be made retroactively to the period or periods during which the rates based on the periods audited were established.

(f) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.

86.9 Patient days. (a) A "patient day" is the unit of measure denoting lodging provided and services rendered to one inpatient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother's discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

(d) For reimbursement purposes, maternity patient days, pediatric patient days and medical surgical patient days shall be determined by using the higher of minimum utilization factors of 60 percent, 70 perc and 80 percent, respectively, of certified beds or the actual patient days, of care as furnished by the facility. Maternity service patient days, for the purposes of this computation, shall include total inpatient service days for all patients housed in the maternity unit. This subdivision shall become effective for minimum utilization for maternity unit services on January 1, 1973 and for pediatric and medical-services with the rates established based on fiscal data submitted by hospitals for fiscal periods ending in 1972. The provisions of this subdivision may be waived by the State Commissioner of Health, upon application by the health facility for decertification of beds, for seasonal utilization variations, or for similar reasons, in those cases where waiver is found to be a matter of public interest and necessity.

(e) For reimbursement purposes patient days for open heart surgery, coronary angiography and other cardiac invasive procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations or procedures and carrying out fewer than 100, 200 or 25 operations or procedures, respectively, during the reporting period.

(1) Patient days for any facility engaged in open heart surgery and carrying out less than 100 such operations during the reporting period shall be increased by an amount equal to the average length of stay for open heart surgery cases multiplied by the difference between 100 and the actual open heart surgery operations carried out by the facility.

(2) Patient days for any facility engaged in coronary angiography and other cardiac invasive procedures and carrying out less than 200 such procedures during the reporting period shall be increased by an amount equal to the average length of stay for such procedures multiplied by the difference between 200 and the actual procedures carried out by the facility.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants

equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity.

86.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification of reimbursement rates by article IX-C corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.

86.11 Computation of basic rate. (a) Basic rates shall be computed on the basis of allowable fiscal and statistical data submitt by the medical facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

(b) Reimbursement rates for emergency and clinic outpatient services shall be computed on the basis of allowable costs for such services and the units of service.

(1) Units of service for facilities providing radiotherapeutic services and carrying out less than 6000 procedures during the reporting period shall be increased by the difference between the number of procedures carried out and 6000.

(2) Units of service for facilities providing renal dialysis services and carrying out less than 1200 procedures if a hospital unit or 3000 procedures if a free standing chronic renal dialysis treatment center shall be increased by the difference between the number of procedures carried out and either 1200 or 3000 depending on the type of facility.

(3) The provisions of paragraphs (1) and (2) of this subdivis may be waived by the State Commissioner of Health upon application the health facility in those cases where waiver is found to be a matter of public interest and necessity.

86.12 Payment for referred ambulatory services. Effective July 1, 1970, payments to hospitals for services to referred ambulatory patients shall be on a fee-for-service basis in accordance with State fee schedules promulgated for the appropriate services.

86.13 Groupings. (a) For the Purpose of establishing ceilings, medical facilities shall be grouped as follows:

(1) Type of medical facility.

(i) hospitals part of or affiliated with teaching centers or maintaining a substantial program of graduate education by number and size of American Medical Association and American Dental Association approved residency programs, adjusted by wage geographic differentials;

(ii) general hospitals;

(iii) special hospitals by type;

(iv) independent out-of-hospital health facilities;

(v) home health agencies.

(2) Geographic areas for non-teaching hospitals.

(i) New York City area;

(ii) New York suburban area (Nassau, Suffolk, Rockland and Westchester counties);

(iii) Upstate standard metropolitan statistical areas;

(iv) Upstate non-SMSA.

(3) Geographic areas for medical facilities other than hospitals.

(i) Western New York hospital service region;

(ii) Rochester hospital service region;

(iii) Central New York hospital service region;

(iv) Northeastern New York hospital service region;

(v) Long Island hospital service region;

(vi) Northern Metropolitan hospital service region;

(vii) New York City hospital service region.

(4) Size of medical facility.

(i) Teaching hospitals, smaller programs:

(a) Up to 100,000 patient days;

(b) 100,001 to 125,000 patient days;

(c) 125,001 to 150,000 patient days;

(d) 150,001 and over patient days.

(ii) Teaching hospitals, larger programs:

- (a) Up to 175,000 patient days;
- (b) 175,001 to 225,000 patient days;
- (c) 225,001 and over patient days.

(iii) Voluntary general, non-teaching (NYSMSA):

- (a) Up to 25,000 patient days;
- (b) 25,001 to 50,000 patient days;
- (c) 50,001 to 75,000 patient days;
- (d) 75,001 to 100,000 patient days;
- (e) 100,001 and over patient days.

(iv) Voluntary general, non-teaching (upstate SMSA):

- (a) Up to 25,000 patient days;
- (b) 25,001 to 50,000 patient days;
- (c) 50,001 to 80,000 patient days;
- (d) 80,001 and over patient days.

(v) Voluntary general, non-teaching (non-SMSA):

- (a) Up to 15,000 patient days;
- (b) 15,001 to 30,000 patient days;
- (c) 30,001 to 45,000 patient days;
- (d) 45,001 to 75,000 patient days;
- (e) 75,001 to and over patient days.

(vi) Public, non-teaching:

- (a) Up to 20,000 patient days;
- (b) 20,001 to 40,000 patient days;
- (c) 40,001 and over patient days.

(vii) Proprietary, non-teaching:

- (a) Up to 20,000 patient days;

(c) 40,001 to 60,000 patient days;

(d) 60,001 and over patient days.

(5) Sponsor

(i) voluntary;

(ii) public;

(iii) proprietary.

(b) Where one group contains an insufficient number of medical facilities needed to establish a reimbursable ceiling, such institutions shall be considered as part of another comparable group.

(c) Facilities with costs less than 75 percent or over 125 percent of the weighted average cost of the group will be excluded from the ceiling computation. Such facilities will be subject to any ceilings developed on the basis of the facilities remaining in the group.

86.14 Ceilings on payments. (a) Ceilings as specified in this section for comparable groups of medical facilities will be established for the computation of reimbursement rates for care provided. The ceilings shall be considered prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) In computing the allowable costs for inpatient routine services for hospitals, no amount shall be included that is in excess of the weighted average cost of routine inpatient services of all hospitals in the group. For the purpose of this computation, routine inpatient services shall not include capital costs, costs of schools of nursing, costs of interns and residents, and costs of ancillary services. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of the weighted average cost of ancillary services per discharge. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, costs of interns and residents and costs of routine inpatient services. Effective with base year 1975 hospitals determined at any time during the base year for rate computation purposes to be providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council shall not be included in their appropriate groups for the purpose of determining ceilings, but will be subject to any ceilings developed on the basis of facilities remaining in the group.

(c) In computing the rates for care provided by community based home health agencies, no amount may be included in a rate that is in excess of the agency charges or in excess of 110 percent of the weighted average cost of all agencies in their group. For hospital based home health agencies, no amount may be included in a rate that is in excess of 110 percent of the weighted average cost of community based agencies in their area.

(d) (1) In computing the medical facility rates for methadone maintenance treatment programs, no amount shall be included that is in excess of:

(i) For treatment and diagnostic centers, the cost included in the rate for employees' salaries and fringe benefits shall not exceed 115 percent of the customary employee cost, as determined by the commissioner, by geographic area, required to staff a facility based on care to 300 patients. Such computation shall be based on an allowable staffing consisting of the full time equivalent of one physician, two nurses, six counselors, two vocational specialists, one clinic administrator and six additional non-professional employees.

(ii) For hospital based methadone maintenance treatment programs, the rate shall not exceed 150 percent of the ceiling, by geographic area, as determined in subparagraph (i) of this paragraph.

(2) The State Commissioner of Health may waive the ceiling limitations of this subdivision for those which have received the prior budget approval of a State agency and such agency finds and recommends to the State Commissioner of Health that he determines that such costs are reasonably related to the costs of efficient production of such services.

(e) Hospitals operated by the Health and Hospital Corporation will be identified with respect to type and size with the appropriate group of voluntary facilities developed in accordance with Section 86.13 and any ceilings established for the voluntary group of facilities will be applied to such hospitals.

86.15 Adjustments to basic computed rate. (a) Payment rates shall be established on a prospective basis.

(b) To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of capital costs, realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a medical facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.

(ii) Nonpayroll administrative and general expense.

(iii) Nonpayroll household and maintenance expense.

(iv) Nonpayroll dietary expense.

(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories.

Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) During the rate period the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

86.16 Final rates. No retroactive adjustments shall be made in rates certified pursuant to this Part. This shall not preclude rate adjustments to correct errors in the determination of such rates. However, errors resulting from submission of information by a medical facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulting from the rate computation process may be corrected if brought to the attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.

86.17 Revisions in Certified Rates. (a) The State Commissioner of Health may consider only those applications for prospective revisions

[illegible] Reg.
76-43.
[illegible]

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a medical facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 86.16;

(3) significant increases in the over-all operating costs of a medical facility resulting from the implementation of additional p[illegible] staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the Commissioner;

(5) requests for waivers of any provisions of Part 86 for which waivers may be granted by the Commissioner as prescribed in specific sections; and

(6) changes in the method of providing services which result in a lower over-all cost for the services provided.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) In view of the commissioner's responsibility for rates paid by government agencies and article IX-C corporations, and for revisions in such rates, each medical facility shall elect for the remainder of its rate period, whether such request covers the government agency rate, the article IX-C rate or both. The existing review procedures employed by article IX-C corporations are in no way intended to be affected by this subdivision.

(d) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(e) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the commissioner shall notify the requesting party of his determination.

(f) In reviewing appeals for revisions to certified rates the commissioner may refuse to accept or consider an appeal from a health facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances subdivision (d) of this section shall not be effective until the date the appeal is accepted by the commissioner

(g) Any facility determined by the State Hospital Review and Planning Council, after notice and opportunity to submit relevant material, to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions. A hearing procedure shall exist after action by the Hospital Review and Planning Council.

(h) Per diem inpatient rates for hospitals shall be adjusted during each rate period to provide for the underpayment or overpayment of costs attributable to the prior year actual utilization being above or below that used in the rate calculation for the prior year, exclusive of minimum utilization adjustments as provided for in section 86.9 of this Part. In the determination of this adjustment variable costs will be excluded in the calcuation and utilization changes of five percent or less will be disregarded.

86.18 Rates for services. (a) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, separately identify all inclusive prospective rates for inpatient services, emergency services and clinic services.

(b) Payment for newborns shall be made at one-third of the mother' rate.

(c) Payments by governmental agencies and corporations organized and operating in accordance with article IX-C of the Insurance Law for days of care in excess of 60 consecutive days for inpatients in a general hospital shall be at an amount equal to the rate promulgated less 16.67 percent of such rate unless the facility has in operation an effective program of control over utilization of such services which is in compliance or consistent with regulations and requirements certified or approved by the State Department of Health for medical utilization review of inpatient services.

86.19 Rates for medical facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

(a) The usual and customary rates, for comparable services, in the geographic area.

(b) Satisfactory cost projections.

(c) Allowable actual expenditures.

(d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

86.20 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service.

86.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principle of reimbursement developed for determining payments under the title XVIII (medicare) program.

(b) Allowable costs may not include costs for open heart surgery or renal dialysis, except for emergencies, in facilities not approved by the State Commissioner of Health for this service.

(c) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs may not include amounts in excess of reasonab or maximum title XVIII (medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(e) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particul item.

(f) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(g) Reserved

(h) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to their owners, operators or employees.

(i) Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(j) Allowable costs shall not include the direct or indirect costs of advertising, public relations or promotion except in those instanc where the advertising is specifically related to the operation of the facility and not for the purpose of attracting patients.

(k) Effective for fiscal years ending in 1976 and thereafter allowable costs per unit of service (inpatient day, clinic visit, etc.) in a base year will not include any cost increases over the allowable costs in the prior year which are in excess of the inflation factor used by the Department in determining the reimbursement rate in effect during such base year unless the cost increases in the base year resulted in a rate revision related to such year in accordance with §86.17.

(l) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(m) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising, or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner pursuant to section 86.21(f)

86.22 Recoveries of expense. (a) Operating costs shall be reduc by the cost of services and activities which are not properly chargea to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold for use outside the medical facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to employees;

(5) employee cafeterias;

(6) meals provided to special nurses or patients' guests;

(7) operation of parking facilities for community convenience;

(8) lease of office and other space of concessionaires providing services not related to medical service;

(9) tuitions and other payments for educational service, room and board and other services not directly related to medical service.

86.23 Depreciation. (a) Reported depreciation based on historical cos is recognized as a proper element of cost.

(b) In the computation of rates effective January 1, 1975 for v tary facilities, depreciation shall be included on a straight line method on plant and non-movable equipment. Depreciation on movabl equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digits metho Depreciation shall be funded unless the Commissioner of Health shal have determined, upon application by the facility, and after invit written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates (effective January 1, 1975) for public facilities, depreciation is to be included on a straight line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight line basis o plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(e) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Part. In lieu of depreciation and interest, on the loan financed portion of the facilities, as allowable costs, however, the State Commission of Health shall allow level debt service on the mortgage loan, toget with such required fixed charges, sinking funds and reserves as may be determined by the commissioner as necessary to assure repayment of the mortgage indebtedness.

(f) Article IX-C corporations may elect to include in their reimbursement rates depreciation computed by a method other than tha used in subdivisions (b), (c) and (d) of this section, subject to approval by the commissioner.

86.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money marke at the time the loan was made. Also, the interest shall be paid to lender not related through control, ownership, affiliation or perso relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restric by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

(d) Interest on capital debt in excess of 50 percent of the net depreciated value of buildings and fixed equipment for voluntary facilities shall not be considered an allowable cost unless the Stat Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested par that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

(e). Interest on capital debt incurred in part or in whole after July 1, 1971 that is in excess of 75 percent of the net deprec value of buildings and fixed equipment for proprietary facilities shall not be considered an allowable cost. In instances where capita debt exceeds 75 percent of such value and the amount of interest considered as an allowable cost is limited, the computation of the reimbursement rate shall include either an amount equal to the amount which would have been included under section 86.29 of this Part had the operators invested additional capital equal to the amount on which interest is not considered an allowable cost or the interest paid, whichever is lower. In no event shall the total amount on whi either interest or return on equity is computed exceed such net depreciated value. In these cases, return on equity shall be compute on the basis of the percent return in effect as of the date o[illegible]ich the debt was incurred. Interest related to refinanced mortgage indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the mortgage then being refinanced and only if such indebtedness is equal to or less than the then undepreciated capital of the facility. To the extent that refinanced mortgage indebtednes is in excess of the then unpaid principal of the mortgage being refinanced or is greater than the then undepreciated capital cost, the amount of such excess shall be deemed to be a return of equity, requiring recomputation of the return on investment allowance for ne equity capital as such return on investment is computed pursuant to the provisions of section 86.29 of this Part. In order to qualify as allowable costs, all expenses related to the refinancing of mortg indebtedness shall be economically necessary to the continued operati of the facility. If qualified refinancing results in lower property costs, an appropriate downward adjustment in rates shall be made.

57-44 34

86.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86.26 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

86.27 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

86.28 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to the medical facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies and a return on the equity capital of the related organizati

86.29 Return on investment. (a) In computing the allowable cos of a proprietary medical facility, there shall be included an allowanc of a reasonable return on the net equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner as reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for these assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider' investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation for patient care activities.

86.30 Capital cost reimbursement. (a) The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86.23, 86.24, 86.29 of this Part and all such costs shall be approved in amount and nature by the Commissi of Health as he shall determine is appropriate, proper and in the public interest, and be certified and audited as actually having been expended; provided, however, that;

(1) with respect to a facility for which a rate has been determined and certified by the Commissioner of Health prio to March 10, 1975, the Commissioner of Health

37

may continue such method and computation of such rate or make such modifications and changes to lower such rate as in his judgment are necessary and proper and in the public interest and

(2) with respect to a facility which has been established by the Public Health Council, and for which a rate has not been determined and certified by the Commissioner of Health prior to the effective date of this section, and a legally binding arms length lease was the basis for the establishment approval granted by the Public Health Council, the Commissioner of Health may determine and certify a rate on the basis of such lease.

86.31 Termination of service. The Division of Health Economics in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86.8(f) of this Part.

86.32 Sales, leases and realty transactions. (a) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner of Health, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86.23, 86.24, 86.29 and 86.30 of this Part.

(b) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realt transaction had not occurred. This subdivision shall not be constr as limiting the powers and rights of the commissioner to change rat computations generally under section 86.30 of this Part, or specifi when based upon previous error, deceit or any other misrepresentatio or misstatement that has led the commissioner to determine and certi [illegible]te which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facili is terminated.

86.33
NOTE

This section has been deleted because it deals solely with other sections that have been previously deleted and, therefore, has no relevance to this submittal.

40

86.34 Interim rules for residential health care facilities. For the purpose of reporting and rate certification for residential health care facilities, the Part 86 rules in effect on October 8, 1975, shall remain in effect for an interim period until regulations have been promulgated pursuant to §§ 2807 and 2808 of the Public Health Law. The provisions of sections 86.15(b)(4), 86.17(a) and (b), and 86.21(k), filed with the Secretary of State on November 26, 1975 apply to residential health care facilities as of said date.

Received__________

Entered in Docket G.

Entered in Diary For__________

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER and BUFFALO GENERAL HOSPITAL, on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York and DAVID MATTHEWS as Secretary of the U.S. Department of Health, Education and Welfare,

Defendants.

---X

CIVIL ACTION
No. 76 Civ. 2027
JUDGE LASKER

The defendants Toia, Whalen, Goldmark and Carey (hereafter referred to as the State defendants) answering the complaint herein by their attorney, LOUIS J.LEFKOWITZ, Attorney General of the State of New York, respectively:

1. Admit the allegations of paragraphs 7, 8, 9, and 10 of the complaint except they deny those portions of the said paragraphs which allege they were acting contrary to the Constitution and laws of the United States or of the State of New York.

2. Admit the allegations of paragraphs 11, 16, 19, 20, 21, 22, 23 and 24 of the complaint and of paragraphs 43 and 45 of the complaint.

3. Deny knowledge or information sufficient to form a belief as to the truth of the allegations of paragraphs 4, 5, 6, 27, 28 and 46 of the complaint.

4. Admit the allegations of paragraphs 25 and 26 of the complaint in so far as they state that the plaintiffs have been reimbursed for in-patient services up to the present at interim rates, to wit the 1975 rates.

5. Admit the allegations of paragraph 30 of the complaint except they deny either the existence of a "freeze" on 1976 rates for in-patient services or that the plaintiffs are being reimbursed at less than reasonable costs under the interi rates.

6. Deny the allegations of paragraph 31 of the complaint except the first sentence thereof.

7. Deny the allegations of paragraph 32, 33, 34, 35, 36 and 37 of the complaint.

8. Deny the allegations of paragraphs 38, 39, 40 and 41 of the complaint.

9. Admit the allegations of paragraph 44 of the complaint but deny knowledge or information sufficient to form a belief as to the allegations of said paragraph that the cost of delivery of out-patient services to Medicaid patients is greater in 1976 then in 1975.

10. Admit the allegations of paragraph 47 of the complaint except the last sentence thereof.

11. Admit the allegations of paragraph 48 of the complaint except the last sentence thereof.

12. Deny the allegations of paragraphs 49, 50, 51, 52 and 53 of the complaint.

AS AND FOR A FIRST SEPARATE AND AFFIRMATIVE DEFENSE, THE STATE DEFENDANTS ALLEGE:

13. Public Law No. 94-182, § 111, 89 Stat. 1054, referred to in paragraph 21 of the complaint which required the States to consent to suit in Federal Court by providers of inpatient hospital services and to waive the immunity from such suit under Amendment XI to the Constitution of the United States is unconstitutional and beyond the power of the Congress to enact. The State of New York executed its consent under protest and by reason of the fact that failure to execute the consent would have cost the State upwards of $40,000,000 in Federal Funds. The State executed the consent but expressly reserved the question of the propriety of the demand for this waiver. See letter dated March 31, 1976 from defendant Toia to Commissioner Toby of the Department of Health, Education and Welfare attached hereto as Exhibit "A".

The State defendants assert that this Court has no jurisdiction under said Public Law 94-182, nor under any other of the statutes cited in paragraphs 12 and 13 of the complaint.

Said Public Law No. 94-182 § 111 is violative of the XI Amendment to the Constitution and of the equal protection of the laws provided for in the XIV Amendment to said Constitution.

AS A SECOND, SEPARATE AND AFFIRMATIVE DEFENSE, THE STATE DEFENDANTS ALLEGE:

14. This action against the State defendants is an action against them as officials of the State of New York. The State has not by constitutional provision or statutory enactment- consented to suit in the Federal Courts nor to a waiver of its

sovereign immunity from suit in Federal Court. This Court is without jurisdiction.

AS A THIRD, SEPARATE DEFENSE,
THE STATE DEFENDANTS ALLEGE:

15. By Chapter 76 of the Laws of New York of 1976, the Medicaid rate of payments to hospitals for out-patient services was set at 100% of the level of payment made in 1975. Chapter 76, § 11(2)(c). Said Chapter 76 is constitutional and not violative of the Social Security Act or Federal Regulations issued thereunder. Count II of the complaint and the prayer for injunctive relief set forth in the complaint would necessarily restrain and enjoin the operation of this statute by the State defendants. Such restraint may only be ordered by a district court of three judges. 28 U.S.C. § 2281, 2284.

The State defendants respectfully request that a three judge district court be convened to adjudicate the issue.

Wherefore, the said State defendants ask judgment dismissing the complaint.

Dated: New York, New York
June 14, 1976

Yours, etc.,

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for State Defendants
Office & P. O. Address
Two World Trade Center
New York, New York 10047
Tel. (212) 488-3391
By

Jesse J. Fine
JESSE J. FINE
Assistant Attorney General

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12243

PHILIP L. TOIA
EXECUTIVE DEPUTY
COMMISSIONER

March 31, 1976

Dear Bill:

Enclosed is the State Plan amendment demanded by you under penalty of fiscal sanctions in your Action Transmittal, SRS-AT-76-14(MSA) dated January 28, 1976. This submission is designed to facially comply with the requirements of Section 111, P.L. 94-182, December 31, 1975.

Please be advised, however, that there are serious questions being raised by this and other states as to the constitutionality of the requirements imposed by this statute. Accordingly, this submission should not be interpreted as an acquiescence by us of the legal appropriateness of this demand. Indeed, we expect such questions to be resolved in an appropriate legal forum in the near future.

Sincerely,

Phil

Philip L. Toia

Honorable William Toby
Acting Regional Commissioner
Social & Rehabilitation Service
Region II
Department of HEW
Federal Building
26 Federal Plaza
New York, New York 10007

APR 1 12 03 PM 1976

EXHIBIT A - p. 1

EPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OCIAL AND REHABILITATION SERVICE
ashington, D. C. 20201

Submit 6 Copies

1976

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

O: REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION NY

TRANSMITTAL NUMBER: 76-8

STATE: New York

PROGRAM IDENTIFICATION: XIX

PROPOSED EFFECTIVE DATE: January 1, 1976

YPE OF PLAN MATERIAL (CHECK ONE)

☐ NEW STATE PLAN
☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
☒ AMENDMENT

OMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

EDERAL REGULATION CITATION

P.L. 94-182, Section 111

UMBER OF THE PLAN SECTION OR ATTACHMENT

Revised page 24a-Title XIX Plan
as required by SRS-AT-76-14

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT

Page 24a

UBJECT OF AMENDMENT

State Consent to Suit

VERNOR'S REVIEW (CHECK ONE)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

GNATURE OF STATE AGENCY OFFICIAL

PED ME: Stephen Berger

TLE: Commissioner

TE: March 30, 1976

TURN TO:
NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 1 APR 1976

DATE APPROVED: MAY 1976

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

William Toby

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: William Toby

TITLE: Acting Regional Commissioner

REMARKS

EXHIBIT-A
P 2

Citation
45 CFR
250.70
F.R. 40-36

4.27 Disclosure of Information on Providers of Health Care Services and Contractors.

The State agency has established procedures for disclosure of information on providers of services, contractors, carriers, intermediaries and State agencies. These procedures meet all requirements of 45 CFR 250.70.

P.L. 94-182
Sec. 111

4.28 State Consent to Suit

The State hereby consents to allow suit in Federal court by or on behalf of providers of inpatient hospital services with respect to payment of reasonable costs of such services, furnished for any period after June 30, 1975, pursuant to section 1902(a)(13)(D) of the Act. The State waives any immunity from such a suit under the eleventh amendment to the Constitution or otherwise.

EXHIBIT A - p. 3

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

-----------------------------------x

HOSPITAL ASSOCIATION OF NEW YORK STATE, et al., :

Plaintiffs, :

v. : 76 Civ 2027

PHILIP L. TOIA, et al., :

Defendants. :

-----------------------------------x

New York, N.Y.
July15, 1976 4:00 PM

BEFORE:

Hon. MORRIS E. LASKER,
District Judge

APPEARANCES:

PROSKAUER, ROSE, GOETZ & MENDELSOHN, Esqs.,
Attorneys for plaintiffs
BY: JACOB IMBERMAN, Esq., of Co unsel

LOUIS J. LEFKOWITZ, Esq.,
Attorney General, State of New York
BY: JESSE J. FINE, Esq., Assistant Attorney General

ROBERT B. FISKE, Jr, Esq.,
United States Attorney, Southern District of New York
BY: JOHN O'CONNOR, Esq., Assistant United States Attorne

el 2

THE COURT: Earlier today because of matters of concern to the Court in relation to the issues that have been tentatively presented tothe Court, I called all counsel and asked them to come for a conference.

In various ways in my telephone conferences directly to each of the counsel, I expressed some reservations in my mind as to whether it might be a futility to press the motions which have been discussed by counsel with me in the past.

First, as I understood it, although it's being clarified by this discussion, was the motion to be submitted by the plaintiffs for a preliminary injunction to declare, as I understand it, the rates or the procedure by which the rates which have been now set by the State, have been -- excuse me -- to declare the rates or the procedure to be illegal under the act.

I have serious doubt whether if such a determination required a decision by the Court as to what constituted reasonable costs of medical care, a trial court could perhaps in any event make such a decision, but in any event make it on the basis of a preliminary application.

I express my doubt to the Attorney General as to the liklihood of declaring the Federal statute unconstitutional on the ground brought to my attention by him yesterday, that it requires the state as a condition of receiving f ederal benefits, to waive the state's sovereign immunity under the Eleventh Amendment.

After the parties arrived here, I mentioned to Mr. Imberman another matter which is extraneous but in a desire to be altogether candid with the parties I felt should be expressed, and that was a concern on my mind to be assured that this case was not being promoted or expedited, since it had been dormant until recently, although I understand the reasons why as a -- I think I said tool in connection with the bargaining process relating to the existing strike.

Mr. Imberman expressed his unha-piness that I had even suggested such a matter and I told him I only wanted to be assured that that was not the case; and he gave me the assurance I requested.

MR. IMBERMAN: I'd like to say preliminarily, your Honor, that this case has not beendormant. What happened is, in May we brought an action because the Commissioner of Health had frozen the Medicaid rates contrary to law, and it was just paying the hospitals at the '75 rate.

We brought an action compelling them to promulgate rates and we were waiting for the federal government

el 4

to file its answer, and they had 60 days and they took every one of their days; so there was nothing we could do by motion for summary judgment or anything until that happened.

In the interval the state promulgated rates and we are now, and I told your Honor a week ago that we'd amend our complaint because we felt that what had happened was totally illegal, and we would seek a preliminary injunction because the result of these new rates was something worse than the freezing, because the 91 hospitals in the state, voluntary hospitals are being now paid at a rate less than 1975.

The preliminary injunction that we will ask for, your HOnor, and I will file my papers tomorrow, is merely to maintain the status quo; merely to direct the state to conintue to pay those 91 hospitals at least the rate they were paid in 1975. And I submit that in today's economy, with the inflation that we have been subject to, that giving a hospital less money in 1976 --

THE COURT: Let's not argue the merits.

MR. IMBERMAN: Well, the point is that it's almost a prima facie situation for the granting of a preliminary injunction just to maintain the status quo.

THE COURT: That is what I want to know subject to learning more from your papers and your witnesses, that

el 5

I don't agree that it automatically follows that because you get less today than yesterday, you're not necessarily getting enough today. I will agree that it is a significant point to make and it is to be assumed, I suppose, that the state was not going to pay deliberately twice as much last year than was the true cose of medical care. But it just doesn't settle the case like that.

MR. IMBERMAN: I willalso say to your Honor zhat we will calculate these rates because they are based on regulations which constitute an amendment to the state plan, which amendment has not been approved by the Secretary of Health, Educaiton and Welfare, and that under the cases automatically makes that regulation invalid; and it seems to me almost mandates a ruling by your Honor that at least there ought to be a preliminary injunction to hold the status quo. And I call your Honor's attention to a case decided in April by Judge Barlow in the United States District Court of New Jersey. It's called New Jersey Hospital Association V. Ann Klein, the Commissioner of the State of New Jersey; Civil action 76-64, the District Court for the District of New Jersey. I'm not sure it's been published, but if it is, we'll find it. I will leave you this decision.

el 6

THE COURT: We can make a copy of it.

MR. IMBERMAN: In that case, what the State of New Jersey had done was promulgated a freeze I think at 6.7 percent, in other words, they wouldn't give any increases in Medicaid above 6.7 percent. They there they admitted, just as no one will deny here, the regulation promulgating that freeze was not approved by the Secretary of HEW; and Judge Barlow granted summary judgment on that basis.

He said, "Here the defendants do not deny that th ceiling rule has been implemented without the prior approval of the Secretary of HEW. As we have previously indicated, our view is that the pre-implementation approval is clearly required by federal law,"citing the statute and regulations. "According, we will enter summary judgment for the plaintiffs on that contention alone." I am quoting.

There are other cases that hold the same. That plus what will be in our affidavits which will demonstrat e the manner in which these unapproved regulations operate, I submit, your Honor, will clearly entitle us to preliminary injunction.

I intend -- I tell your Honor now, I will press the point; I would like to make my motion, I will submit my order to show cause tomorrow.

If your Honor denies it, I will take an appeal.

el 7

THECOURT: I expect you to, of course.

MR. IMBERMAN: This has the greatest public interest.

THE COURT: I understand that. I am not acting as if it is a casual matter, by any means. Indeed, the purpose of my calling you here was because I know you both take your propositions seriously; to have a frank exchange as to whether the District Court could perform any more useful function in this case than simply acting one way or another so the matter can be appealed. Because I am sure if I grant your injunction, Mr. Fine is going to appeal.

These are not minor matters. The state isn't going to stand pat for me to freeze these things without even asking the other judges in this building. At least, I wouldn't if I were he.

It isn't that I don't understand the seriousness of it; it's to see whether we can do anything more.

In any event, I think we have cleared the air as far as I am concerned, in a very satisfactory was.

Yes, Mr. Fine.

MR. FINE: First of all, I should like to suggest to you that my point about the constitutionality of the federal requirement that the state consent to be sued in the federal court with respect to inpatient Medicaid rates

el 8

is I think based on more than a flimsy theory, shall I say.

You understand that the Social Security Act is enacted under the Article of the constitution which provides that the federal government may levy taxes for the good and welfare of the people.

THE COURT: Yes.

MR. FINE: What relation has the requirement in Congress -- I don't want to argue the merits, but my basic point is that the amendment of the Social Security Act which required the state to consent to being sued in this court has nothing at all to do with the general overall purposes of the good and welfare of the people of the United States.

Second, I should like to make clear on e other thing. The penalty imposed on the state for refusal to sign a consent is not that its plan becomes disqualified. It does not lose all of its federal assistance. All that the statute then goes on to say is if the state doesn't sign the consent to be sued, the state loses 10 percent of its federal reimbursement, which in the case of the State of New York for the quarter ending March 31, I think, would amount of $40 million.

In other words, it is not as if the federal government were saying if you do not sign the consent your

el 9

plan is entirely nullified; we just impose a penalty on you.

MR. IMBERMAN: What is that, 10 percent?

MR. FINE: Yes. In other words, we'd have lost about $40 million in the first quarter and I presume the same in the second quarter. The state when it did exercise the consent under this financial duress in effect reserved, and the exhibit annexed to our answer showed that, reserved the right to attack constitutionality.

I mentioned the last time there are an enormous number of actions brought by the states to declare this part of the law unconstitutional. I have briefs from some of the other Attorneys General and I think they are valid.

As far as the out patient Medicaid rates, it's Correct that Congress never required, nor did HEW require consent by the jurisdiciton with respect to the outpatient or emergency rates.

As far as the amended complaint speaks of this Court's jurisdiction with respect to those rates, it is quite clear that the court is without jurisdiction because the states never consented.

MR. IMBERMAN: I think the consent that was filed was a consent to the Medicaid act, and included out patient

el 10

and inpatient.

THE COURT: I suppose you better be prepared at least for a jurisdictional argument.

MR. FINE: I have a suggestion which I make with some prepidation, but which I think makes sense, and I think Mr. Imberman agrees with me. When I got a copy of his letter this morning, it was clear that he is going to present voluminous factual affidavits.

I have seen affidavits in other proceedings involving rate cases by Mr. England, Dr. Pomerantz, etc. What these affidavits contain will be basically statements of fact with which I have no quarrel. I can't quarrel with Dr. Pomerantz of Mount Sinai when he says he now pays interns $15,000 a year, whereas last year he paid $12,000; that his nurses' costs have gone up, etcetera.

When a doctor is onthe stand I am certainly not going to attempt to show that he is lying in these facts.

The state's defense likewise will be in effect a statement by-- I hope -- the Assistant Commissioner in charge of these matters, which will state the basis upon which the state reached these rates.

What I am suggesting to your Honor is a very simple thing. What purpose will a hearing serve?

THE COURT: I haven't asked that question here,

el 11

but I may have indicated to one or more of you over the phone whether a hearing would be necessary. Of course, that depends to a very substantial extent, Mr. Fine, as to what your position will be. If you will not contest substantially the facts set forth in the affidavit that Mr. Imberman submits, then of course we won't need one unless you come up with affidavits which, even though they don't contest the facts in his, will contain facts which he would contest.

I don't know whether --

MR. IMBERMAN: I don't know. Is Mr. McCann your witness?

THE COURT: I do think that Mr. Fine is probably correct even in light of what you said, that what you are disagreeing about are not the underlying facts, but the theories.

MR. FINE: I am personally willing to concede tha your hospitals' costs in 1976 have gone up. There is no argument about it. The price of a can of beans has gone up and the price of a subway token has gone up to fifty cents.

MR. IMBERMAN: The hospital buys a lot of cans of beans.

MR. FINE: Since I have seen your letter this morning and the voluminous affidavits you are going to

el 12

submit, what purpose will be served if I sit two days and cross examine your witnesses on what their costs are? They are not going to lie.

THE COURT: May I ask this: am I coorect in the impression that I got fromyour letter, that your witnesses on the whole will simply elaborate on what will be contained in the affidavits?

MR. IMBERMAN: Yes, to some extent. I think what is very important is Mr. Ingraham's testimony as to how these regulations operate and how they serve to produce under-reimbursement. How they produced less than reasonable coses.

THE COURT: Maybe that is the key to the question of the time we should spend here. I am no more anxious to spend time here than you are or Mr. Fine is. Perhaps as you think it over you will be able to limit the number of witnesses to those who don't argue about whether the intern is getting more this year than last year, and to assume, as I guess Mr. Fine is saying, that to the extent your affidavits which you will want to put in, that expenses are up, will go unchallenged, and simply present witnesses who talk about application of these procedures and you tell me how you reach yours.

MR. IMBERMAN In some cases --

el 13

THE COURT: I don't know whether the rest of this needs to be onthe record.

MR. IMBERMAN: I would prefer to have it on the record.

IN the Mount Sinai case, which is not atypical of the 300 voluntary hospitals in the state, Mount Sinai built this new Annenberg building which your Honor may have noticed on Park Avenue.

THE COURT: Notice? How can you help it.

MR. IMBERMAN: Exactly. A very beautifyl, extraordinarily efficient project which combines aspects of the medical school and the hospital. Very costly; filled with very costly equipment.

Every nickel that was spect in construction of the Annenberg building and filling it with this elaborate equipment for lifesaving was with the advance approval of the State of NewYork; every aspect.

THE COURT: Advance approval --

MR. IMBERMAN: For the construction, the manning; they knew what the budgets were, they knew what we were going to put in there and what it would cost to operate it. And it was approved.

And now they come along in 1976 and say, sorry, fellows, we are going to reduce your rate below 1975.

el 14

How can they do this?

THE COURT: They will have to explain it.

MR. FINE: But Dr. Pomerantz can say this in an affidavit and we aren't going to controvet it. All I am saying to you is the factual material which I am sure you are going to present in your affidavits, and that goes as far as Mr. Ingraham's explanation that you want to have the testimony about, as to how these formulas have operated i the past and operate right now, can be set forth in documents.

MR. IMBERMAN: I would ask your Honor at least in the case of Mr. Ingraham, I ask that your Honor hear him, because he cannot -- we can't put in all of that vast detail. This man was executive vice president for reimbursement for Blue Cross for many years. He is the outstanding expert in the state, and I'd like your Honor to hear him to explain to you how this operates.

THE COURT: I will make myself available for whatever is necessary in the public interest. But I ask both counsel -- and I have no reason to doubt that I will get this cooperation -- that we not be required to listen to witnesses any more than necessary for a sound determinatio in this matter.

I would be willing to hear Mr. Ingraham, and I

el 15

don't suppose Mr. Fine is going to worry about hearing one plaintiff's witness. And I'd be willing to hear, and I'd even like tohear a witness on the part of the state so that Mr. Imberman and I can ask any questions we want to so I can be absolutely sure I understand how they did what they did and how they justify it. And then it would be up to me to determine how they justified it.

MR. FINE: I am hopeful the witness can be Mr. McCann. But I can't answer you until I see your affidavits. You recall that when we came here on July 3rd, you said that you would have your amended complaint; I think you said you would have it that week.

I wanted to ask your Honor, I have a motion I want to make for dismissal for lack of jurisdiction under the federal statute. I don't know how to handle that expeditiously. I can have a notice of motion ready tomorrow and you can't have a motion ready until next week.

MR. IMBERMAN: I have a suggestion and if I am out of bounds, shut me off completely, your Honor.

I am taking into consideration Judge Lasker told us he is going to leave on vacation.

THE COURT: That is secondary.

MR. IMBERMAN: I just want to make a point. This is a matter of grave public interest, no aspect of

el 16

which should not receive the fullest consideration from the Court and everyone else.

I think Mr Fine and I should have an opportunity to brief these questions for your Honor as thoroughly as possible. Will you agree to maintain the status quo for another month and let us brief these things fully?

You will have time to make your motion with regard to jurisdiction and when the Judge comes back --

THE COURT: I'd like to intervene at this point. Of course any Judge would always be happy if the parties agree to maintain the situation where the pressure would be less on the parties. But I don't want Mr. Imberman's suggestion, which is a reasonable suggestion in the sense that it is often the kind of suggestion made in these cases, to even be answered by the State before I say that I will make myself available for as long and as intensively as necessary.

I can easily return from the place where I will be on vacation. I don't want the state to anwer Mr. Imberman's question bearing in mind any effect which it may have on my own arrangments.

MR. FINE: I thank your Honor for that statement. I had the notion that if your Honor, for instance, should decide my motion in favor of the State, that you might not

el 17

even find it necessary to decide the application for the temporary injunction.

THE COURT: You are right.

MR. FINE: So I was thinking almost the converse of what Mr. Imberman suggested.

THE COURT: Thatis the way it ordinarily works. The reason I suggested the schedule that I did yesterday, it's apparent with regard to your motion we don't need any evidence. With regard to the other motion we need it.

What I was saying in effect is, look, boys, let me get the evidence; then I will sort out the legal questio as soon as possible.

MR. FINE: I will make any motion as quickly as I can --

THE COURT: You can make it simultaneously.

MR. FINE: I can serve my notice of motion and affidavit probably tomorrow morning. You will give me until Friday to write the brief, right?

MR. IMBERMAN: Well, I will want some time after I get the brief. I'm really not quite sure that I understand what the motion is. I'd like to see it in writing because I can't believe that Mr. Fine is seriously saying tha we have no right to bring any action of any kind whatsoever under the Medicaid law merely because the state was "forced" dl 18

to file this waiver of the Eleventh Amendment. Because cases have been filed under the Medicaid statute on precisely these same points before, and the Eleventh Amendment question was argued even without waivers, and the cases stood; so that you know, I just don't think Mr. Fine means everything he is saying. And I'd like to see his papers.

THE COURT: We will.

MR. IMBERMAN: I will file my papers tomorrow and we will still go ahead on Tuesday.

THE COURT: We still go ahead on Tuesday at which time we decide whether we need to have anything on Friday or we don't.

MR. IMBERMAN: I'd like to have my witness on Tuesday, at least Ingraham.

THE COURT: Yes.

MR. IMBERMAN: After you have read my affidavit and you decide you won't controvery anything, let me know.

THE COURT: It if is possible to wind up the hearing in a full day, you will let me know.

Mr. Fine, after you have reviewed Mr. Imberman's affidavits, will you on Monday morning at the latest -- I won't be able to look at them over the weekend -- advise him whether you will contest them and, if so, to

el 19

what extent, and whether you would want to have anybody else, in view of his suggestion that he have anybody else testify beside Ingraham.

MR. FINE: Yes.

THE COURT: In addition, will you let me know whether you will be calling any witnesses. If, for example, you are o nly going to have Ingraham, and I hope we can do it that way, and you will have one or two witnesses to testify as to why you are doing what you are doing, I think that could be done in a day.

MR. FINE: A lot depends on what Mr. Imberman's affidevit says. Judge, you are going tohold this in the courtroom?

THE COURT: Yes. 61[illegible].

MR. FINE: At what time do you start?

THE COURT: I normally start at 10:00.

MR. IMBERMAN: I had asked Mr. Fine whether he would accept service of the subpoena because there are certain documents I'd like at this stage produced, which would be very helpful to Ingraham in connection with his testimony, and I hope you would accept service of a subpoena so I don't have to chase up to Albany.

MR. FINE: I will accept it.

THE COURT: Mr. O'Connor, we have ignored you

el 20

in this discussion, which I'm sure you are very glad of. Is there anything you want to say?

MR. O'CONNOR: No, your Honor.

THE COURT: Thank you, gentlemen.

o0o

☆ U.S. GOVERNMENT PRINTING OFFICE – 1974-[illegible]

7//

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Washington, D. C. 20201

Submit 6 Copies

MS [illegible]

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

TO: REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION II

TRANSMITTAL NUMBER: 74-41

STATE: New York

PROGRAM IDENTIFICATION: XIX

TYPE OF PLAN MATERIAL (CHECK ONE)

☐ NEW STATE PLAN
☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
☒ AMENDMENT

PROPOSED EFFECTIVE DATE: June 24, 1976

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

FEDERAL REGULATION CITATION: 45 CFR 250.30

NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A Page 35

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT: Attachment 4.19A

SUBJECT OF AMENDMENT: Section 86.26 of Part 86 Commissioner of Health Administrative Rules and Regulations

GOVERNOR'S REVIEW (CHECK ONE)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL:

TYPED NAME: Philip L. Toia

TITLE: Commissioner

DATE: July 12, 1976

RETURN TO: NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 20 JUL 1976

DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:

SIGNATURE OF REGIONAL OFFICIAL:

TYPED NAME: [illegible]

TITLE: Acting Regional Commissioner

4

REMARKS: See attached ltr. from N.Y. [illegible] and ltr from Reg. Comm. to N.Y. [illegible]

RECEIVED SERVICES SEP 30 3 24 PM '76

86.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86.26 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services. In computing allowable costs related to salaries and fringe benefits for interns and residents for purposes of reimbursement, a portion of such costs will be eliminated from rate computations on the basis that this elimination represents the minimum amount properly chargeable to education activities not directly related to patient services.

86.27 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable costs. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee,

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12203

PHILIP L. TOIA
COMMISSIONER

CARMEN SHANG
COUNSEL

SEP 29 1976

September 26, 1976

Mr. William Toby
Acting Regional Commissioner
Department of Health, Education
and Welfare
Social Rehabilitational Services
Region II
Federal Building
26 Federal Plaza
New York, NY 10007

Dear Bill:

The attached submission 76-41 (revised) is made pursuant to suggestions made by your staff.

We assume this satisfies all remaining issues with Part 86 as it may apply to the New York State Title XIX Plan.

As is true of all other submissions relevant to Part 86, New York intends that they be effective January 1, 1976. Your Office indicates that such retroactive approval is not permissible under Federal law. We strongly disagree with this position, but have conformed under protest by deleting date references in order to obtain approval of the Title XIX Plan. We do this without prejudice to our right to appeal your Office's ruling.

Sincerely,

Carmen Shang/jd

Carmen Shang

CS/jd

Enclosure

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

--x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

--x

76 Civ. 2027

CLASS ACTION
AMENDED COMPLAINT
(Judge Lasker)

Plaintiffs, by their attorneys Proskauer Rose Goetz & Mendelsohn, for their Amended Complaint respectfully allege:

PRELIMINARY STATEMENT

1. This is a Class action for preliminary and permanent injunctive relief and a declaratory judgment brought by the Hospital Association of New York State, Inc., ("HANYS"), located in Albany, New York, Misericordia Hospital Medical Center ("Misericordia") located in New York City, Buffalo General Hospital ("Buffalo"), located in Buffalo, New York, The Genesee Hospital ("Genesee") located in Rochester, New York and The Mount Sinai Hospital ("Mount Sinai") located in New York City on behalf of themselves and the nonprofit voluntary and public hospital members

of the Association rendering hospital services on or after January 1, 1976 to patients under the joint federal and state medical assistance program provided for under Title XIX of the Social Security Act, 42 USC §1396 et seq. ("Medicaid Program"). These non-profit hospitals comprise the Class herein.

2. On January 1, 1976 defendants Philip L. Toia, Robert P. Whalen, Peter Goldmark and Hugh L. Carey ("State Defendants") imposed a freeze on Medicaid in-patient and out-patient hospital reimbursement rates in the State of New York. Under this freeze, the Members of the Class have been reimbursed for services rendered to Medicaid patients in 1976 at their 1975 rates. The 1975 rates had been calculated by these defendants as reimbursement for the hospitals' 1975 reasonable costs. The general inflationary movement of the economy has caused an increase in the cost of providing hospital services which is substantially higher in 1976 than it was in 1975. Thus, these frozen 1975 rates, which represented reimbursement of 1975 reasonable costs, do not reimburse hospitals for their 1976 reasonable costs. Because of this fact, the freeze violated Title XIX of the Social Security Act 42 USC §1396-1396i ("Medicaid Act"), which requires that hospitals be reimbursed their reasonable costs under the Medicaid Program.

3. On July 1, 1976, after six months of this illegal rate freeze, the State Defendants finally formulated and approved 1976 in-patient rates. These new in-patient rates continue to deny hospitals reimbursement of their

1976 reasonable costs. For approximately 30% of the hospitals in the Class, these 1976 in-patient rates are, in fact, lower than the 1975 rates which they were paid under the freeze. The State Defendants have continued the freeze on Medicaid out-patient rates.

4. The 1976 in-patient rates were calculated pursuant to several new regulations which have not been approved by the Secretary of the United States Department of Health, Education and Welfare as part of the Plan governing the New York State Medicaid Program. Such approval is required under the Medicaid Act.

5. These new regulations specifically exclude a portion of a hospital's reasonable costs from its reimbursement rate through the imposition of a system of arbitrary ceilings. If these regulations continue in effect they will destroy the ability of the New York hospitals to provide the quality health services they now make available to all the people of this State. Their ultimate effect will be to frustrate the rational planning and development of health systems in New York as well as the requirement under the Medicaid Act that hospital services be made available to Medicaid patients.

6. By denying the hospitals reimbursement for the reasonable costs of providing necessary health and hospital services to Medicaid patients the State Defendants have violated and will continue to violate the Medicaid Act and Regulations, Article VI of the United States Constitution, the Fourteenth Amendment to the United States Constitution, the New York State Constitution, the New York State Public

Health Law, the New York State Executive Law, and the New York State Social Services Law. Defendant Matthews is in violation of the Medicaid Act and Regulations and the Fifth Amendment to the United States Constitution by failing to compel the State Defendants to comply with the Medicaid Act and Regulations.

COUNT I

PLAINTIFFS

7. Plaintiff HANYS is a New York not-for-profit corporation composed of approximately 300 nonprofit voluntary and public hospitals and other health care institutions in this State. Its principal place of business is at 15 Computer Drive West, Albany, New York and it is organized for the purpose of providing administrative and legal assistance to nonprofit hospitals in New York State.

8. Plaintiff Misericordia is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its principal place of business is 600 East 233rd Street, Bronx, New York.

9. Plaintiff Buffalo is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its principal place of business is 100 High Street Buffalo, New York.

10. Plaintiff Genesee is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its principal place of business is 224 Alexander Street, Rochester, New

York.

11. Plaintiff Mount Sinai is a nonprofit New York corporation which provides in-patient and out-patient hospital services to Medicaid-eligible patients. Its principal place of business is Fifth Avenue and 100th Street, New York, New York.

DEFENDANTS

12. Defendant Philip L. Toia or his predecessor in office is, and at all times relevant hereto was, the Commissioner or Executive Deputy Commissioner of Social Services of the State of New York ("Commissioner of Social Services"). The New York State Department of Social Services is the single state agency designated pursuant to the New York State Plan for Medical Assistance and the New York State Social Services Law to administer or supervise the administration of the medical assistance program under the Medicaid provisions of the Social Security Act. In implementing the challenged regulations, defendant Toia acted and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

13. Defendant Robert P. Whalen is, and at all times relevant hereto was, the Commissioner of Health of the State of New York ("Commissioner of Health"). In implementing the challenged regulations defendant Whalen has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

14. Defendant Peter Goldmark is, and at all times relevant hereto was, the Director of the Budget of

the State of New York ("Director"). In implementing the challenged regulations defendant Goldmark has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

15. Defendant Hugh L. Carey is, and at all times relevant hereto was, the Governor of the State of New York ("Governor") and as such vested with the executive power of the State. In implementing the challenged regulations defendant Carey has acted, and is acting, under color of the law of the State of New York and contrary to the Constitution and laws of the United States.

16. Defendant David Matthews is, and at all times relevant hereto was, the Secretary of the United States Department of Health, Education and Welfare ("Secretary") and is the federal officer ultimately responsible for the lawful administration of the Medicaid Program.

JURISDICTION AND VENUE

17. This action arises under the Medicaid Act, 42 USC §1396-1396i, and the regulations promulgated thereunder, 42 USC § 1983, the Administrative Procedure Act, 5 USC § 701 et seq., Article VI of the United States Constitution, the Fifth and Fourteenth Amendments to the United States Constitution, the New York State Constitution, the New York State Public Health Law, the New York State Executive Law and the New York State Social Services Law.

18. Jurisdiction is vested in this Court under 28 USC §§1331, 1343, 1361, 2201 and 2202, 42 USC §1396a(g) and principles of pendent jurisdiction. The amount in

controversy exceeds the sum of $10,000 exclusive of interest and costs.

19. Venue lies in this District pursuant to 28 USC §1391.

CLASS ACTION ALLEGATIONS

20. Plaintiffs bring this action pursuant to Rul 23(b)(2) of the Federal Rules of Civil Procedure on behalf of themselves and all other nonprofit hospital members of HANYS rendering hospital services to Medicaid patients on or after January 1, 1976. The Class is so numerous that joinder of al members is impractical. Upon information and belief, there are approximately 275 hospitals in the Class. There are questions of law and fact common to the Class, including whether certain regulations that have been promulgated and implemented by the State Defendants in conflict with the approved New York State Plan for Medical Assistance are in violation of the Medicaid Act and Regulations, the Supremacy Clause (Article VI of the United States Constitution), the Fifth and Fourteenth Amendments to the United States Constitution, the New York State Constitution, the New York State Public Health Law, the New York State Executive Law and the New York State Social Services Law. Plaintiffs will fairly and adequately protect the interests of the Class. Defendants have acted and have refused to act on grounds generally applicable to the Class, thereby making appropriate injunctive and declaratory relief with respect to the Class.

STATEMENT OF FACTS

21. The United States provides funds to a state which is funding and administering a State Plan approved by the Secretary for the provision of medical assistance to certain categories of low income and indigent persons in accordance with law. This joint federal-state program is known as the Medicaid Program, and is governed by Title XIX of the Social Security Act, 42 USC §1396 *et seq*., and the regulations promulgated thereunder.

22. The Medicaid Act and regulations require that a State Medicaid Plan provide for payment to hospitals of the reasonable cost of in-patient hospital services rendered to Medicaid patients in accordance with methods and standards developed by the State and approved in advance of implementation by the Secretary. Pursuant to the Medicaid Act and regulations, changes cannot be made in the methods or standards for determining in-patient hospital reimbursement rates without the prior approval of the Secretary. The Medicaid Regulations, 45 C.F.R. §250.30, provide that the reasonable cost of in-patient hospital services shall be determined in accordance with the standards and principles for ascertaining reasonable cost under the Medicare Act, Title XVIII of the Social Security Act 42 USC §1395-1395pp (with an exception not relevant hereto) or under an alternate method which has been approved in advance by the Secretary.

23. One of the criteria which the Medicaid regulations require the Secretary to consider before he approves an alternate method for the determination of

reasonable cost is that the alternate method give "[a]-ssurance of adequate participation of hospitals and availability of hospitals services of high quality to title XIX [Medicaid] recipients." 45 C.F.R. §250.30(a)(2)(ii)(d).

24. The New York State Plan for Medical Assistance ("State Plan") which has been approved by the Secretary was prepared by the New York State Department of Social Services.

25. Under the Plan, the Commissioner has agreed that

> "As a condition for receipt of Federal funds under title XIX of the Social Security Act, the NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES...agrees to administer the program in accordance with the provisions of...[the] State plan, the requirements of Title XIX of the Act, and all applicable Federal regulations and other official issuances of the Department." Preface to Section I.

26. On March 30, 1976 the Commissioner executed an amendment to the Plan pursuant to 42 USC §1396b(g) consenting to suits in federal court by or on behalf of providers of in-patient hospital services with respect to payment of reasonable costs of such services and waiving any immunity from such suits under the Eleventh Amendment to the United States Constitution or otherwise.

27. Pursuant to the Medicaid Act and regulations, the Plan includes in-patient hospital services among the services which will be provided to eligible Medicaid patients.

28. The State Plan sets forth "the methods and standards used, after review and approval, for the payment of the reasonable cost of in-patient hospital services."

Section 4.19-A. These methods and standards have been approved by the Secretary as an alternate method of reimbursement.

29. The final Medicaid in-patient hospital reimbursement rates for services rendered on or after January 1, 1976 by members of the Class were approved on July 1, 1976. These rates were not calculated in accordance with the approved State Plan.

30. The final 1976 Medicaid in-patient hospital reimbursement rates for services rendered by members of the Class do not reimburse these hospitals for the reasonable costs which they incur in providing in-patient hospital services to Medicaid patients.

31. The Commissioner of Health has announced that the 1976 in-patient hospital reimbursement rates approved on July 1, 1976 are retroactive to January 1, 1976. The members of the Class relied on the approved State Plan when rendering in-patient hospital services to Medicaid patients prior to the approval of these rates. Since the 1976 Medicaid rates were not calculated in accordance with the approved State Plan, these hospitals have incurred reasonable costs for which they will not be reimbursed.

32. The 1976 rates approved for more than 30% of the hospitals in the Class ~~have~~ had 197~~6 rates approved for them which~~ are lower than the rates which the State Defendants calculated as reimbursement for these hospitals' 1975 reasonable costs. As a result of the inflation to which the entire economy has been subject, the

hospitals' reasonable cost of providing in-patient hospital services to Medicaid patients has been and is greater in 1976 than it was in 1975. Thus, paying a hospital in 1976 at a rate which is less than its 1975 rate necessarily results in the hospital receiving less than its reasonable cost.

33. Since the 1976 Medicaid rates are retroactive to January 1, 1976 the State Defendants will seek a recovery of funds from hospitals whose 1976 rates are lower than their 1975 rates. Such a recovery will further threaten the financial viability of these hospitals and their ability to provide quality health care.

34. The State Defendants have adopted and are implementing for plaintiffs and the members of the Class methods and standards for the calculation of Medicaid in-patient hospital reimbursement rates which conflict with the methods and standards in the State Plan. These inconsistent methods and standards include three regulations: 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26.

35. Neither 10 N.Y.C.R.R. §86.14(b) nor 10 N.Y.C.R.R. §86.21(k) nor 86.26 have been approved by the Secretary.

36. 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 impose a series of arbitrary ceilings on the amount of reimbursement which will be paid to a hospital for rendering in-patient hospital services to Medicaid patients. These ceilings exclude from a hospital's reimbursement rate part of the reasonable cost incurred by it in treating Medicaid patients.

37. Pursuant to §2803 of the New York Public Health Law, regulations governing the establishment of Medicaid in-patient hospital reimbursement rates must be adopted by the New York State Hospital Review and Planning Council ("Council") subject to the approval of the Commissioner of Health. The Council has refused to adopt 10 N.Y.C.R.R. §86.26.

38. Pursuant to §101-a of the New York State Executive Law, the Temporary President of the New York State Senate and the Speaker of the New York State Assembly must be given at least 21 days prior notice of the adoption of a New York State regulation before it can become effective. This requirement applies to all regulations except those relating to the organization or internal management of an agency or those that constitute emergency measures necessary for the preservation of the public health, safety or general welfare. The Temporary President of the New York State Senate and the Speaker of the New York State Assembly never received 21 days notice prior to the adoption of 10 N.Y.C.R.R. §86.26. This regulation does not relate to the organization or internal management of an agency. Nor is 10 N.Y.C.R.R. §86.26 an emergency measure necessary for the preservation of the public health, safety or general welfare.

39. The Medicaid Regulations, 45 C.F.R. §246.10(a)(3) require that an approved state plan provide for a medical care advisory committee which "will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient

participation in the program of the agency." The State Plan provides for a Medical Advisory Committee in accordance with 45 C.F.R. §246.10. Section 365-c(2) of the New York State Social Services Law provides that the Medical Advisory Committee "shall advise the commissioner [of Social Services] with respect to [Medicaid] health and medical care services" and requires that the Committee meet at least once a year. The Medical Advisory Committee has not met within the past year and was not consulted about the adoption or implementation of 10 N.Y.C.R.R. §§86.14(b), §86.21(k) or 86.26.

40. The New York Public Health Law requires hospitals in New York State to provide certain in-patient hospital services. Pursuant to the statute, the members of the Class are obligated to provide in-patient hospital services to Medicaid-eligible patients. As a result of the promulgation and implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26, the members of the Class will be reimbursed at less than reasonable cost for these services which they are required by law to furnish.

41. Pursuant to the Medicaid Act and regulations and the State Plan, in-patient hospital services are supposed to be made available under the Medicaid Program to all Medicaid-eligible patients. As a result of the promulgation and implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26, many of these patients will be unable to obtain in-patient hospital care because of the adverse financial impact of these regulations on the members of the Class.

STATUTORY CLAIMS

42. The State Defendants have violated and continue to violate the Medicaid Act and regulations and the State Plan by formulating and applying 1976 Medicaid in-patient hospital reimbursement rates that were not calculated in accordance with the alternate reimbursement method contained in the State Plan and approved by the Secretary.

43. The State Defendants have violated and continue to violate the Medicaid Act and regulations, the New York State Plan and the New York Public Health Law by formulating and approving 1976 Medicaid rates that do not reimburse the reasonable cost of in-patient hospital services rendered Medicaid patients.

44. The implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 violates the Medicaid Act and regulations and the New York State Plan in that these regulations have not been approved as part of the New York State Plan by the Secretary.

45. The adoption and implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 violates the Medicaid Act and regulations, the State Plan and the New York Public Health Law because these regulations arbitrarily prevent the reimbursement of the reasonable costs of in-patient hospital services rendered Medicaid patients.

46. The adoption and implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 violates the Medicaid Act and regulations, the New York State Plan and

the New York State Social Services Law in that it was done without proper prior consultation with the Medical Advisory Committee.

47. The adoption and implementation of 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 violates the Medicaid Act and regulations, and the State Plan since it will result in the availability of in-patient hospital services to Medicaid eligible patients being reduced below legally required levels.

48. The implementation of 10 N.Y.C.R.R. §86.26 violates the New York State Public Health Law since this regulation was put into effect without having been adopted by the Council.

49. The implementation of 10 N.Y.C.R.R. §86.26 violates the New York State Executive Law since this regulation was put into effect without 21 days prior notice to the Temporary President of the New York State Senate and the Speaker of the New York State Assembly.

CONSTITUTIONAL CLAIMS

50. The calculation and payment of the Class' 1976 Medicaid in-patient hospital reimbursement rates violates the Supremacy Clause of the United States Constitution, Article VI, because it was done in accordance with regulations which have the effect of state law and which are in conflict with the laws of the United States on the same subject.

51. The adoption and implementation of 10 N.Y.C.

R.R. §§ 86.14(b), 86.21(k) and 86.26 have the effect of state law and violate Article I, Section 10 of the United States Constitution because they impair contractual obligations between Plaintiffs and the State of New York.

52. The adoption and implementation of 10 N.Y.C. R.R. §§86.14(b), 86.21(k) and 86.26 have the effect of State law and violate the Supremacy Clause of the United States Constitution, Article VI, because these regulations are in conflict with the laws of the United States on the same subject matter.

53. The adoption and implementation of 10 N.Y.C. R.R. §§86.14(b), 86.21(k) and 86.26 violates the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and the New York State Constitution insofar as the members of the Class are deprived of their property without due process of law when they provide Medicaid beneficiaries with in-patient hospital care for which reimbursement under these regulations is less than reasonable cost.

54. The adoption and implementation of 10 N.Y.C. R.R. §§86.14(b), 86.21(k) and 86.26 violates the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and the New York State Constitution insofar as they are retroactively applied to reduce reimbursement for in-patient hospital services provided Medicaid patients prior to the date on which they were adopted.

55. The implementation of 10 N.Y.C R.R. §86.26

violates the due process clause of the Fourteenth Amendment to the United States Constitution since this regulation was put into effect in violation of Plaintiffs' procedural due process rights.

56. Plaintiffs have no adequate remedy at law.

57. The members of the Class have suffered and will continue to suffer irreparable injury unless they are reimbursed the reasonable cost of in-patient hospital services rendered Medicaid patients.

COUNT II

58. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1-57 with the same force and effect as if fully set forth herein.

59. By Chapter 76 of the Laws of 1976 of the State of New York, adopted March 30, 1976, the members of the Class' Medicaid reimbursement rates for out-patient hospital services rendered during the period January 1, 1976 through March 31, 1977 have been frozen at the level of their 1975 out-patient rates.

60. The 1975 Medicaid rates for out-patient hospital services were calculated in advance of 1975 on the basis of 1973 allowable costs for such services which were then adjusted to account for inflationary cost increases expected to occur prior to and during 1975. The reasonable cost to each of the members of the Class for the delivery of out-patient hospital services to Medicaid patients is greater in 1976 than it was in 1975

and is less than the maximum rate allowed under the Medicaid Act and regulations, namely, the reasonable customary charge. Thus, using 1975 rates as the rates for reimbursing 1976 out-patient hospital services necessarily results in the hospitals receiving less than their reasonable costs.

61. Pursuant to the Medicaid Act and regulations, and State Plan, out-patient hospital services are supposed to be made available under the Medicaid Program to all Medicaid-eligible patients.

62. If the freeze on 1976 Medicaid out-patient hospital reimbursement rates continues, many of these patients will be unable to obtain out-patient hospital care because of the adverse financial impact of the freeze on the members of the Class.

63. Under the Medicaid regulations, 45 C.F.R. §250.30(a)(6), a state plan must provide for rates

> "which are designed to enlist participation of a sufficient number of providers of services in the [Medicaid] program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population."

At present, the out-patient departments of the members of the Class are the only source of the medical care and services provided for in the New York State Plan for a substantial number of Medicaid-eligible persons. If the freeze on 1976 Medicaid out-patient hospital reimbursement rates continues, many of these patients will be unable to obtain these services from members of the Class with the result that these services will not be available to these patients to the extent they are available to the general population.

64. The New York State Public Health Law requires hospitals in New York State to provide certain out-patient hospital services to persons in need thereof. Pursuant to this statute, the members of the Class are obligated to provide certain out-patient hospital services to Medicaid-eligible patients. Under the freeze on 1976 rates for these services, the members of the Class will be reimbursed at less than reasonable cost for these services.

CLAIMS

65. The freeze on the 1976 Medicaid out-patient hospital reimbursement rates violates the Medicaid Act and regulations and the New York State Plan since under it the availability of these services to Medicaid-eligible patients will be reduced below legally required levels.

66. The freeze on 1976 Medicaid out-patient hospital reimbursement rates has the effect of state law and violates Article I, Section 10 of the United States Constitution because it impairs contractual obligations between Plaintiffs and the State of New York.

67. The freeze on 1976 Medicaid out-patient hospital reimbursement rates has the effect of state law and violates the Supremacy Clause of the United States Constitution, Article VI, because it is in conflict with the laws of the United States on the same subject matter.

68. The freeze on 1976 Medicaid out-patient hospital reimbursement rates violates the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and the New York State Constitution insofar as the members of the Class are deprived of their property without due process of law when they are required to provide Medicaid patients with hospital care for which they receive reimbursement at levels less than reasonable cost.

69. Plaintiffs have no adequate remedy at law.

70. The members of the Class have suffered and will continue to suffer irreparable injury unless they are reimbursed the reasonable cost of out-patient hospital services rendered Medicaid patients.

WHEREFORE, Plaintiffs pray:

(a) That this Court preliminarily enjoin the State Defendants and their successors, officers, agents, servants, employees and attorneys from reimbursing any plaintiff or member of the Class for services rendered on or after January 1, 1976 at an in-patient hospital Medicaid rate which is less than its 1975 rate.

(b) That this Court preliminarily and permanently enjoin the State Defendants and their successors, officers, agents, servants, employees and attorneys from promulgating any amendment to the State Plan which would authorize reimbursement for hospital services rendered Medicaid patients at less than reasonable cost.

(c) That this Court issue an injunction ordering the State Defendants, and their successors, officers, agents, servants, employees and attorneys to comply with all federal laws and rules and regulations of the United States Department of Health, Education and Welfare applicable to the New York Medicaid Program, including reimbursement on the basis of reasonable cost so long as the State of New York continues to participate in the Federal Medicaid Program.

(d) That this Court declare and adjudge that 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 are unlawful.

(e) That this Court declare and adjudge that the freeze on out-patient hospital reimbursement rates for services rendered Medicaid patients on or after January 1, 1976 is unlawful.

(f) That this Court permanently enjoin the State Defendants, and their successors, officers, agents, servants, employees and attorneys from applying or attempting to apply 10 N.Y.C.R.R. §§86.14(b), 86.21(k) and 86.26 to in-patient hospital reimbursement rates for services rendered Medicaid patients on or after January 1, 1976.

(g) That this Court permanently enjoin the State Defendants, and their successors, officers, agents, servants, employees and attorneys from applying or attempting to apply the freeze on out-patient hospital reimbursement rates to services rendered Medicaid patients on or after January 1, 1976.

(h) That this Court enjoin Defendant Matthews and his successors, officers, agents, servants, employees and attorneys from approving any amendment to the State Plan which would provide for the reimbursement of hospital services rendered to Medicaid patients at less than reasonable cost.

(i) That this Court order Defendant Matthews to exercise such authority as is provided by law to compel compliance of the State Defendants with the Medicaid Act and Regulations:

AND, that Plaintiffs be awarded their costs and such other and further relief as to this Court may seem just and proper.

Dated: New York, New York
July 16, 1976.

PROSKAUER ROSE GOETZ & MENDELSOHN

By s/s Jacob Imberman
Jacob Imberman
A member of the Firm
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022
(212) 593-9000

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---------------------------------------x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

---------------------------------------x

ORDER TO SHOW CAUSE WITH TEMPORARY RESTRAINING ORDER

76 Civ. 2027

(Judge Lasker)

Upon the amended complaint and the affidavits of S. David Pomrinse M.D., Irvin G. Wilmot, Darrell G. Hartline and James C. Ingram, each verified July 16, 1976, and upon all proceedings had herein, and good cause appearing therefor, it is hereby

ORDERED that defendants, their officers, agents, servants, employees and attorneys appear before this Court in Room 619 of the United States Courthouse, Foley Square, New York, New York, on the 20th day of July 1976 at 10:00

o'clock in the forenoon of that day, or as soon thereafter as counsel can be heard to show cause why an order should not be entered granting plaintiffs' motion for a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure pending final determination of this action enjoining defendants Toia, Whalen, Goldmark and Carey ("State Defendants") and their successors, officers, agents, servants, employees and attorneys from reimbursing any plaintiff or member of the Class for services rendered on or after January 1, 1976 at an in-patient hospital Medicaid rate which is less than its 1975 rate; and it further appearing to the Court from the pleadings attached hereto that a temporary restraining order preliminary to the hearing for a preliminary injunction should issue enjoining reimbursement at less than the 1975 Medicaid rate of any plaintiff or member of the Class; that defendants unless so enjoined threaten to reimburse plaintiffs and some members of the Class at less than the 1975 rate and that this reimbursement will likely occur prior to said hearing date unless restrained by an order of this Court; that the reimbursement at less than the 1975 rates with respect to plaintiffs and others will cause them immediate and irreparable injury in that it will seriously and permanently impair the ability of plaintiffs and the members of the Class to render hospital and health services to the public; and plaintiffs having made no previous application for the relief requested herein, it is hereby

ORDERED that for a period not to exceed ten days

~~after the entry of this order or until the day of July, 1976 at o'clock in the noon or as soon thereafter as counsel can be heard, unless this order be dissolved prior thereto or extended then or thereafter whichever is sooner, State Defendants, their officers, agents, servants, employees and attorneys be and hereby are temporarily enjoined and restrained pending the hearing and determination of this motion from reimbursing any plaintiff or member of the Class for services rendered on or after January 1, 1976 at an in-patient hospital Medicaid rate which is less than its 1975 rate, and it is further~~

~~ORDERED that security as required by FRCP 65(c) be waived, and it is further~~

ORDERED that personal service of this order to show cause ~~and temporary restraining order~~ together with a copy of the papers upon which it is based upon the New York State Attorney General, and the United States Attorney for the Southern District of New York and if made on or before 5 o'clock in the after noon of the 16th day of July, 1976, shall be deemed sufficient service thereof.

Dated: New York, New York
July 16, 1976

Issued at
4:10 p.m.

Morris E. Lasker
United States District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- -x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U.S. Department of Health, Education & Welfare,

Defendants.

- -x

76 Civ. 2027

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

JAMES C. INGRAM, being duly sworn, deposes and says:

1. I am a principal in the firm of Ingram, Weitzman, Mertens & Company, Inc., a hospital financial management consulting firm. I submit this affidavit in support of plaintiffs' application for a temporary restraining order and preliminary injunction.

Background of Deponent

I received my Bachelor's Degree in Business Administration from Pace College in 1952, and I was associated with the New York University Medical Center from 1949 until 1953, serving the last two years as Director of Finance. I was employed at Blue Cross from 1953 through 1975. From 1953 until 1961 I had responsibility for the Blue Cross hospital relations program and the payment of claims. From 1961 through 1975 I was vice-president for provider reimbursement for Blue Cross and Blue Shield of Greater New York, the Greater New York Metropolitan Area Blue Cross Plan. In that position, I had primary responsibility for the administration of Blue Cross reimbursement to its member hospitals under both its own insurance program and the Medicare program for which it acts as the fiscal intermediary. From 1967 through 1975 I was responsible for the hospital audit program conducted by Blue Cross on behalf of the New York Medicaid and Medicare programs.

The Medicaid Program

2. The Medicaid Program is a joint federal-state program under which medical assistance is provided to poor and low-income individuals. Participation in the Medicaid Program is voluntary on the part of a state. However, in the event a state decides that it wishes to participate in this program it must agree to abide by certain terms and conditions set down by the federal government pursuant to the Medicaid Act. In exchange, the federal government reimburses the state part of the costs which it incurs under the Program.

3. The terms and conditions governing a state's participation in the Medicaid Program are contained in a document entitled the "State Plan for Medical Assistance". The state plan is prepared by the state. However, before it

can become effective it must be approved by the Secretary of Health, Education and Welfare ("Secretary").

4. New York State as a participant in the Medicaid Program has an approved plan for medical assistance ("State Plan"), under which it has agreed to pay for in-patient hospital services rendered to Medicaid patients.

5. Payment is made directly to hospitals on the basis of a daily rate, which is based on the average cost of providing services to all of a hospital's Medicaid patients rather than on the cost of services rendered to any individual Medicaid patient. Thus a hospital will receive the same daily rate for a cancer patient as it will for a patient with appendicitis.

6. In the approved State Plan, New York has agreed to reimburse hospitals the reasonable cost of providing in-patient care to Medicaid patients. The method by which a hospital's reasonable cost is calculated is also part of the State Plan. This method was specifically approved by Secretary when he approved the Plan. This method is what is known as a prospective rate reimbursement method. Under it, rates are calculated prior to the year to which they will apply. For example, 1976 rates must be calculated in 1975. The rationale behind such a system is that advising hospitals in advance of the rate they will be receiving will allow them to more efficiently plan their operations for the coming year. Furthermore, since under such a system there is no retrospective adjustment if a hospital's costs exceed its reimbursement, it is felt that hospitals will be encouraged to contain their costs.

7. Medicaid rates are actually calculated by the State even though they are governed by federal standards. Until this year this was done as follows:

First, a hospital's allowable costs incurred two years prior to the rate year ("base year") were determined. Allowable costs fall into several broad categories: routine costs, ancillary costs, costs of interns and residents, capital costs and costs of schools of nursing. Routine costs include all those costs generally provided patients such as housing, food, administrative expenses and routine nursing as well as costs associated with intensive nursing care units. Ancillary costs are the costs of the departments directly diagnosing and treating patients such as the radiology department, laboratories and operating rooms.

8. Under the approved plan, the routine costs are segregated from all of the other allowable costs and divided by the number of a hospital's base year patient days (annual number of patients x number of days). The result is the hospital's base year routine per diem cost. Hospitals were then grouped according according to certain common characteristics, such as size, and an average routine service per diem cost is calculated for each group. The maximum base year routine service allowable cost is the lower of the actual allowable routine service cost incurred or 110% of the average allowable routine service cost incurred by a group of comparable hospitals. The 110% figure is used rather than the average to compensate for the normal differences in cost that result from the fact that that no two hospitals will operate in exactly the same manner.

9. The final step in the calculation of a hospital's

in-patient Medicaid rate under the approved plan is to adjust a hospital's base year allowable costs after the excess routine service cost has been excluded to account for projected inflationary increases which will occur from the base year to and during the rate year. Projections of these increases are made on the basis of cost indicators such as the consumer and wholesale price indices.

10. The State Defendants did not follow the approved methodology contained in the New York State Plan when it came time to calculate 1976 in-patient hospital Medicaid reimbursement rates. Instead, they first decided to use the hospitals' 1975 in-patient rates as reimbursement for the hospital care provided Medicaid patients in 1976. The hospital economy, like the general economy, has shown a significant inflationary increase between 1975 and 1976. Therefore, reimbursing hospitals for their 1976 costs at their 1975 rates obviously denied them reimbursement for some of their reasonable costs.

11. The State Defendants put this freeze on in-patient hospital reimbursement rates into effect from January 1 - June 30, 1976. On July 1, 1976, they then issued 1976 rates. However, for more than 30% of the hospitals, these new 1976 rates are lower than their 1975 rates.

12. In calculating these new 1976 rates, the State Defendants did not follow the approved State Plan and applied two regulations which are not contained in the approved State Plan: 10 NYCRR §§ 86.14(b), and 86.26. They have adopted another regulation 10 NYCRR §86.21(k), also not part of the approved State Plan, which they intend to apply starting with the calculation of the 1978 rate. Since this

latter regulation limits the amount of a hospital's base year cost which will be allowed in rate calculations it obviously affects the hospital's ability to manage their resources now since 1976 is the base year for the 1978 rate. In this affidavit, I will explain why 10 NYCRR § 85.14(b) and 86.21(k) are arbitrary and capricious and bear no rational relationship to the calculation of a hospital's reasonable costs.

10 NYCRR §86.14(b):
THE ROUTINE AND ANCILLARY CEILINGS

13. 10 NYCRR §86.14(b), a copy of which is annexed hereto as Exhibit A, replaces the State Plan's 110% group average routine per diem cost ceiling with a ceiling equal to the group average routine service per diem cost. It also imposes a ceiling on base year ancillary service costs equal to the group average ancillary service cost per discharge (this is another way of saying per patient) even though there is absolutely no ceiling provided for ancillary service base year costs in the approved State Plan.

14. In analyzing the operation of the routine and ancillary service ceilings it is important to remember that the routine and ancillary service cost figures to which they are applied are actually in the form of a fraction. Therefore, a hospital can be affected by a routine or ancillary service ceiling either because the numerator goes up or the demoniator goes down in one of these fractions.

In the case of the routine ceiling the feaction is:

$$\frac{\text{Total Routine Service Cost}}{\text{Total Patient Days}}$$

In the case of the ancillary ceiling the fraction is:

$$\frac{\text{Total Ancillary Service Cost}}{\text{Total Discharges}}$$

15. A hospital which experiences a decrease in patient days is obviously more likely to be hit by the routine and ancillary ceilings then one showing an increase in patient days.

16. It is easy to see that hospitals are going to vary in their total number of patient days and patients. This is true even for hospitals within the same group. The Medicaid hospital groupings devised by the State recognize this by grouping according to patient days on the basis of a range rather than an absolute number.

17. The use of a mathematical average as a group ceiling on base year operating costs assumes that all hospitals are alike and subject to identical influences in the level of cost incurred. Hospitals are not alike any more than hotels or people are alike. An average family of 3.2 persons is a statistical reality and a factual absurdity.

18. There are a great many factors which can cause similar, efficiently run hospitals to incur different costs. The following are some of the more obvious examples.

PATIENT MIX

19. No two hospitals will have an identical number of patients in their service departments - e.g., medicine, surgery, psychiatry. Two hospitals with identical costs in each of their service departments will have varying average total costs if the mix of patients is not identical. This is illustrated by the following example:

	Hospital A	Hospital B
Surgical Patients		
Cost/In-Patient Day	$ 200	$ 200
Total Annual In-Patient Days	61,000	74,000
Total Cost	12,200,000	14,800,000
Medical Patients		
Cost/In-Patient Day	$ 150	$ 150
Total Annual In-Patient Days	39,000	26,000
Total Cost	5,850,000	3,900,000
All Patients		
Cost/In-Patient Day	$ 180.50	$ 187
Total Annual In-Patient Days	100,000	100,000
Total Cost	18,050,000	18,700,000

The difference in mixed patient days results in an average cost of $180.50 for Hospital A and an average cost of $187 for Hospital B even though the average cost is the same for both hospitals in their medical and surgical departments.

20. Presumably, the use of discharges as a unit of measure in the calculation of the ancillary service cost ceiling is an attempt to reduce the length of stay by the

application of economic sanctions. The fallacious nature of this effort is best illustrated by the schedule below which dramatically illustrates how two hospitals with identical lengths of stay by class of patient could have different overall lengths of stay simply because of variation in the mix of patients.

	Hospital A	Hospital B
Medical-surgical patients:		
Discharges	8,000	6,500
Days	80,000	65,000
Length of stay	10.0 days	10.0 days
Pediatric patients:		
Discharges	1,428	2,857
Days	10,000	20,000
Length of stay	7.0 days	7.0 days
Obstetrical patients:		
Discharges	2,500	3,750
Days	10,000	15,000
Length of stay	4.0 days	4.0 days
All patients:		
Discharges	11,928	13,107
Days	100,000	100,000
Length of stay	8.4 days	7.6 days

21. Clearly, any student of the hospital industry would recognize the foregoing factors and would accept the natural clustering of hospital costs above and below the mathematical average of a group as a direct result of these factors. The use of a group ceiling was never intended to penalize a hospital whose costs were reasonably close to the group average but rather to protect the public from aberration in cost. It is obvious that whenever an average is used, some hospitals must exceed the average while others will be below it. As a result, even if every hospital in a group is operating at maximum efficiency, some will be hurt by the ceilings. This has more to do with the mathematical function of an average than the nature of the things being averaged.

22. The concept of a ceiling based on a mathematical average is not used anywhere in the United States by any third party payor except in New York. Furthermore, I do not believe that any other third party payor uses a separate ceiling on ancillary cost or makes any calculation on a per discharge basis. Rather, we find in use, ceilings based either on a percentage above the average or the use of a fairly high percentile in an array of hospital costs such as is used by the Medicare program.

23. In contrast to the arbitrary ceilings included in 10 NYCRR §86.14(b), the Medicare program uses a ceiling which allows for the natural fluctuation in hospital costs. This ceiling was selected after a great deal of study and deliberation by the Secretary who has overall responsibility for the Medicare Program as well as the Medicaid Program.

The Medicare ceiling is calculated by grouping hospitals and then taking the 80th percentile of a group's routine service cost and adding to it 10% of the median cost.

24. The following example shows the calculation of the Medicare routine ceiling for a group of hospitals and then contrasts it with the Medicaid routine ceiling under 10 NYCRR §86.14(b) for the same group:

Hospital	Cost/Day
1	$100
2	95
3	90
4	85
5	80
6	75
7	70
8	65
9	60
10	55
11	50

80th Percentile - $90/Day
Median - $75/Day

Medicare Routine Cost Ceiling = 80th Percentile
+ 10% Median = $97.50/Day

Hospitals affected by Medicare Ceiling - 1

10 NYCRR §86.14(b) Ceilings Average - $75/Day

Hospitals affected by 10 NYCRR §86.14(b) Ceiling- 1-5

PATIENT AGE

25. Elderly patients require more nursing care than younger patients. Therefore, if a hospital is serving a community which has a high percentage of elderly persons it will have to increase its nursing staff and as a result its costs. These higher routine and specialized nursing services will bring the hospitals routine costs closer to or over the routine ceiling.

26. The higher nursing cost involved in treating elderly persons is recognized by the Medicare Program which provides health care to people over 65. The standard for reimbursement under this Program is, like that under Medicaid, based on reasonable cost. To allow for the greater "reasonable" cost incurred by a hospital in treating elderly persons, Medicare adds 8 1/2% to a hospital's allowable Medicare nursing costs to reflect the additional higher cost of routine nursing.

DESIGN OF PLANT

27. Variations in the physical design of hospitals will influence the calculation of their routine service costs. Every hospital's physical plant is different. Hospitals which have an older physical plant tend to require a greater degree of maintenance than more modern facilities. Some facilities require higher utility costs than others because of such structural characteristics as central air conditioning.

28. The design of a hospital may be such that its different services are physically far apart. This results in higher costs because time is lost in transporting patients within the hospital. While modernization of all hospitals is desirable, it would require an enormous expenditure of capital funds which are clearly not available at the present time. Therefore, hospitals must continue to exist within the limits of their present facilities. It is unreasonable to penalize them for a situation over which they have little if any control.

DEGREE OF UNIONIZATION

29. The degree of unionization (and the extent to which some nonunion hospitals of necessity must follow union

pay and fringe levels) with its attendant effect on pay scales and fringe benefits can produce significant variations in cost between hospitals. Both routine and ancillary costs can be affected since employee costs fall into both categories. For example, the cost of employees in the dietary department is essentially a routine cost, while the cost of a radiology department employee is an ancillary service cost. The effect of unionization is particularly significant with respect to fringe benefits which include paid time off. Unionized and such other hospitals pay approximately 18% for employee time off (e.g., vacations, maternity leave, paid holidays), while in non-unionized hospitals paid time off is roughly equal to 11 or 12 percent of total paid employee time.

INTENSITY OF CARE

30. Hospitals within the same group do not necessarily provide the same types of services. Some may concentrate on providing simpler, more low cost services such as obstetrical care and appendectomies. Others may provide high cost services such as open heart surgery, and orthopedic and cancer treatment. Obviously, hospitals of the latter type will incur higher costs. The effect of the ceilings is to deny reimbursement for some of the reasonable cost of providing this type of treatment, and discourage hospitals from making this care available to the public. The State cannot seriously suggest that the resulting deprivation of care increases hospital efficiency.

10 NYCRR §86.21(k)

31. This regulation imposes a ceiling on base year allowable costs separate and apart from the routine and

ancillary ceilings. It is calculated as follows:

Assume that a hospital's allowable costs in 1975 are $100/in-patient day. Assume that the inflation factor used in calculating the 1976 reimbursement rate projected an inflationary increase of 10% in costs from 1975-76. (Remember that a rate is supposed to be calculated in advance of the year to which it applies and before figures on the actual degree of inflation became available.) The ceiling on 1976 allowable costs would be $110/Day. This would be reflected in the 1978 rate since 1976 would be the base year for the 1978 rate.

32. The use of such a ceiling is irrational for several reasons. In the first place, it is based on an estimate of what the inflation rate will be before any actual data is available. The State Defendants cannot seriously suggest that they will always be able to predict the movement of the economy with complete accuracy. Yet that is the implication inherent in the use of this ceiling.

33. Second, because of the way in which it is calculated, this ceiling affects a hospital not only in the year in which costs exceed the inflation factor, but also in all subsequent years even if the hospital's costs and the inflation rate increase at the same rate in these later years. Furthermore, the amount the hospital is penalized increases in each subsequent year. Thus, if in one year a hospital's cost inadvertently exceeds the State's guess of the inflation rate the hospital will be penalized in an amount far greater than the amount of the excess. This is illustrated by the following example:

Year	Base Year Cost/ In-Patient Day	% of Actual Cost Increase	% of Increase in Inflation Factor	Maximum Base Year Allowable Costs after Application 86.21(k)	Amount Excluded From Base Year Allowable Cost as Result of 86.21(k) Ceiling
1	$100.00	-	-	$100.00	-
2	112.00	12	10	110.00	$2.00
3	120.96	8	8	118.80	2.16
4	129.43	7	7	127.12	2.31
5	139.78	8	8	137.29	2.49

34. If a hospital exceeds the inflation factor in one year the only way it can make sure that it will not be penalized in future years is to reduce future spending below the inflation rate in an amount equal to the excess. Obviously, since a hospital has no control over inflation it can only do this by reducing the quantity or quality of the services it provides. The people who will suffer will be the sick, particularly those who do not have adequate resources to pay for medical care.

35. Third, because the 86.21(k) ceiling is based on the rate of inflation it makes no allowance for cost increases due to expansion of facilities or new technology. Unless this regulation is invalidated, it will, therefore, effectively eliminate all advances in hospital care in New York. Eventually, New Yorkers will only be able to obtain out-moded medical care and the effectiveness of the great teaching institutions of this state will be destroyed.

36. Finally, the §86.21(k) ceiling suffers from the same weaknesses as the routine and ancillary ceilings because it is in effect a mathematical average and makes no allowance for natural differences in hospital operations.

WHEREFORE, it is respectfully requested that the Court issue a preliminary injunction in this action.

James C. Ingram
James C. Ingram

Sworn to before me this
16th day of July, 1976.
Susan Rosenfeld
Notary Public

SUSAN ROSENFELD
Notary Public, State of New York
No. 31-8656000
Qualified in New York County
Commission Expires March 30 1978

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

HOSPITAL ASSOCIATION OF NEW YORK STATE INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U.S. Department of Health, Education & Welfare,

Defendants.

---x

76 Civ. 2027

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

S. DAVID POMRINSE, M.D., being duly sworn, says:

1. I am Executive Vice President of the Mount Sinai Hospital in the City of New York ("Mount Sinai"). I submit this affidavit in support of the plaintiffs' application for a preliminary injunction restraining the defendants from reimbursing any member of the class defined in the complaint for hospital services rendered on or after January 1, 1976 at an in-patient hospital Medicaid rate which is less than the hospital's 1975 rate.

2. This affidavit is divided into two parts. The first part shows how Mount Sinai and similarly situated hospitals will suffer immediate and serious irreparable harm if their Medicaid reimbursement rates are reduced by defendants below the rates they were receiving on January 1, 1975. The second part shows how the changes made by the defendants in the relevant regulations has resulted in a defendants' reimbursement system which fails to reimburse hospitals for their reasonable costs as required by federal law.

BACKGROUND OF DEPONENT

3. I graduated from Western Reserve University in 1941 with the degree of Doctor of Medicine and engaged in private practice from 1946 until 1955. From 1956 to 1958 I was Chief of the Health of the Aged branch of the United States Public Health Service. In 1961 I became Associate Director of Mount Sinai and remained in that position until I became Medical Administrator in 1966. I was appointed Director in 1969 and Executive Vice President in 1975. I am a member of the Board of the Council of Teaching Hospitals of the Association of American Medical Colleges. I am a member of the American College of Hospital Administrators, American Hospital Association, American Public Welfare Association, the Society of Medical Administrators and the New York State Medical Advisory Committee. I am also the Edmond H. Guggenheim Professor of Administrative Medicine in the Mount Sinai School of Medicine of the City University of New York (the "Mount Sinai School of Medicine"). As Executive Vice President I am responsible for Mount Sinai's reimbursement by third-party payors, including Medicaid, and I

am familiar with the financial data submitted to Medicaid by Mount Sinai.

4. I have also been active for many years in two hospital associations of the State of New York, the Hospital Association of New York State ("HANYS") and the Greater New York Hospital Association ("GNYHA"). I am a member of the Board of Trustees of HANYS and serve on its executive Council, and am currently President-elect of GNYHA. My responsibilities for those associations have included the analysis of the various methods of hospital reimbursement used in this State and in the City of New York, as well as the development of effective methods of hospital administration and cost-saving.

5. During my association with the United States Public Health Service from 1956 to 1961, I was involved in analyzing reimbursement methods and in drafting reimbursement legislation, some of which was later the basis for the federal health care laws.

6. In addition, I have either authored or co-authored several articles on hospital administration and reimbursement.

MOUNT SINAI

7. The Mount Sinai Hospital is one of the oldest and largest voluntary teaching hospitals in the United States. Founded in 1852, Mount Sinai has been responsible for numerous advances in medicine and is recognized as one of this country's most renowned medical centers. Since 1963 it has been affiliated with the Mount Sinai School of Medicine.

8. Mount Sinai is considered a "tertiary" medical center; that is, it offers specialized services and facilities not available at smaller community hospitals. These include such services as open heart surgery, CAT scans, neurosurgery and radiation therapy. Patients are referred to Mount Sinai from all over the United States and from foreign countries. In addition, Mount Sinai serves as a general hospital for the New York community and in particular East Harlem and offers out-patient and emergency care through a range of specialized and general medical clinics. Some of Mount Sinai's in-patients pay the established charges themselves, some are covered by conventional insurance or Blue Cross or Medicare and approximately 18% have their charges paid by Medicaid.

9. In 1975 Mount Sinai completed construction of the Annenberg Building. This new facility has 27 floors above ground and three levels below ground for a total of 565,335 usable square feet of floor space. 55% of the space is devoted to the Medical School and 45% to the Hospital. The Annenberg Building offers the most sophisticated diagnosis and treatment facilities currently available and includes among its many features a new pharmacy, a specially designed central sterile supply system, expanded radiology and neuroradiology facilities, 19 additional operating rooms, two additional recovery rooms, and an 18 bed-coronary intensive care unit. The Annenberg Building has enabled Mount Sinai's distinguished medical staff, working with augmented facilities and the most modern and sophisticated equipment, to expand innovative treatments

and therapies and even more effectively to fulfill the institution's long-established international role as a tertiary care center.

PART I: IRREPARABLE INJURY

10. In New York, reimbursement for hospital services rendered Medicaid patients is made under a "prospective" rate setting system. Briefly stated, this means that prior to each calendar year the State is required to establish a reimbursement rate for each hospital for that calendar year. A hospital's prospective rate, while containing incentives for efficiency, must reimburse it for the reasonable cost it incurs in treating Medicaid patients.

11. In 1975, the State defendants promulgated an in-patient rate of $255.49 per patient day as reimbursement for the reasonable costs incurred by Mount Sinai during that year in providing medical services to its Medicaid patients.*

12. Since 1975 there have been substantial increases in the costs of providing services as a result of inflation and other factors over which the hospital has no control. The cost of Mount Sinai's malpractice insurance has risen approximately 225% since 1975. Its food costs have risen 7.7% and it has experienced similar increases in such areas as labor and debt service. As a result, Mount Sinai's costs

---

* The Annenberg Project referred to in paragraph 9 was reviewed by the Department of Health in detail. This included a careful study of Mount Sinai's total operating costs to determine whether there would be adequate reimbursement for the hospital's operating and capital expenses, including the additional costs incurred by reason of the Annenberg Project. Indeed, the Department's conclusions and its approval of the Project and the reimbursement of the rates necessary to sustain it were essential to the Project going forward and, as Exhibit A shows, are tantamount to a guarantee of adequate reimbursement of the costs specified.

have increases above the $255.49 per day the defendants agreed was reasonable and adequate in 1975 to approximately $270 per day in 1976, or a $14.51 increase.

Hospital services continue to "intensify" and become more sophisticated. This is especially so at tertiary care centers such as Mount Sinai which provide the most technologically advanced care available. The State of New York has participated with us in planning these efforts and it has approved in advance our new programs as well as the acquisition of new equipment and capital projects. In 1976 several State approved programs will be implemented which have added capital and labor costs to our overall expenditures. For example, we have completed a new 19-bed cancer unit which provides a focal setting for treating these patients by chemotherapy and serves as the nucleus for the treatment of cancer patients throughout the institution. Budgets for this unit were approved by the Department of Health in the amounts of $734,343 for additional intensive care staffing and $263,411 for other additional expenses.

13. Rather than promulgate prospective rates for 1976 prior to January of that year as required by law, the defendants instead "froze" reimbursement rates at their 1975 levels. Thus, for the first six months of 1976 Mount Sinai receieved the same daily in-patient rate of $255.49 which it had received during 1975. After all efforts to get the defendants to voluntarily lift the freeze had failed, this class action was filed to have the "freeze" declared unlawful under the Medicaid laws since, in the face of obvious inflationary cost increases, 1975 rates could not possibly

reimburse hospitals for their reasonable costs in 1976.

14. Subsequent to the filing of this action the State Defendants adopted new regulations for the calculation of Medicaid in-patie[illegible] hospital reimbursement rates. Those regulations are different from those which the Secretary of Health, Education and Welfare has approved for calculation of Medicaid rates. Moreover, the New York State Medical Advisory Committee, of which I am a member, was never consulted about these regulations. (N.Y.C.R.R.§86.14(b), [illegible] k), 86.26). In fact, this Committee has not met [illegible] the past year. This new methodology and resulting rates it has produced fails to reimburse hospitals for their reasonable costs and in many instances reduces hospital reimbursement rates below their frozen 1975 levels. For example, Mount Sinai's newly promulgated 1976 rate is $240.05 per patient day, as compared to its State approved 1975 rate of $255.49 per patient day. Moreover, since the new 1976 rates are retroactive to January 1, 1976, Mount Sinai will be liable for any reimbursement which it received during the first six months of 1976 in excess of its new 1976 rate.

15. If the use of Mount Sinai's facilities by Medicaid patients remains constant, and there is no reason to believe that it will not, Mount Sinai will suffer a total loss for the year 1976 of $2 million for providing services to Medicaid patients. This loss is based on the difference between the rate it will receive and the reasonable costs it will incur in treating Medicaid patients. These rate reductions take effect immediately.

16. Mount Sinai fully recognizes the realities of the fiscal crisis in New York State and New York City. We have responded responsibly and have made every effort to control our costs. We have begun, on our own initiative, a major, comprehensive effort to increase productivity and reduce costs. To date, 58.6 positions have been eliminated throughout the institution and overtime expenditures have been trimmed significantly. In addition, special programs in the Departments of Radiology, Data Processing and Traffic and Information have resulted in savings. Cutbacks in the Departments of Engineering, Finance, Housekeeping and Surgery are planned for the next few months. Because of these efforts we have been able to keep our overall increase in costs in 1976 over 1975 to 5.6% despite substantial inflation. However, the reduction of Medicaid income to pre-1975 levels completely fails to reimburse Mount Sinai and similarly situated hospitals for their legitimate and reasonable costs and as such is indisputably unlawful under the reasonable cost standards established in the Medicaid law. These unilateral and unlawful cuts, imposed retroactively, will have a devastating impact on Mount Sinai's financial condition and will force an immediate drastic change in the scope and quality of services --services which the State has approved as appropriate and reasonable--which we are able to provide to Medicaid patients and other patients. Indeed, the magnitude of program and other changes which these reductions will require threatens Mount Sinai's continued viability as a major tertiary care center. Unquestionably, unless these unlawful reductions are immediately enjoined, Mount Sinai

and other hospitals whose rates have been reduced will be irreparably and seriously damaged.

PART II: WHY THE MEDICAID METHODOLOGY IS UNLAWFUL

17. In this section I will try to show why the Medicaid reimbursement methodology does not and cannot reimburse hospitals for their reasonable costs in providing medical services to Medicaid patients. These regulations are contained in Part 86 of the administrative rules and regulations of the New York State Commission of Health. My analysis is broken down to show the following: (1) the ceilings imposed on "routine" and "ancillary" costs (A) do not take into account legitimate differences in programs and services offered, patient mixes and other differences among the hospitals in the various groupings to which such ceilings apply and (B) do not take into account legitimate increases in program costs which are incurred after the ceilings are imposed, and (2) the unilateral determination contained in a regulation that only 90% of the salaries paid by the hospitals to interns and residents are reimbursable has no rational basis and represents an arbitrary effort to cut expenditures.

The Ceilings

18. Implementation of the Part 86 regulations produces a per diem rate which is the amount of money which the State will pay a hospital for each day a patient is in the hospital. Under the regulations, the per diem rate has the following components:

"routine" costs, "ancillary" costs, capital costs, house staff costs, school of nursing costs and teaching physician costs. In general, the costs within each category are calculated in accordance with various reimbursement rules and, after ceiling calculations, the components are added together and adjusted for inflation, and the total is divided by the number of a hospital's in-patient days as defined by Medicaid, thus yielding a per diem rate.

19. Medicaid reimbursement for a particular Medicaid patient is not based on the costs incurred by the hospital in providing services to the particular patient but rather on the average cost of providing services to all Medicaid patients. Thus, the hospital will receive the same reimbursement for a cancer patient as it will for a gall bladder patient. This tends to even out in the end and generally produces satisfactory reimbursement as long as all of a hospital's reasonable costs are taken into consideration in developing its per diem rate. However, the State has done something quite different in computing the routine and ancillary components of a hospital's Medicaid reimbursement rate with the consequence that many of a hospital's reasonable costs are disallowed. It is important to explain more specifically why this is so.

20. Briefly stated, for 1976, State Defendants first calculated each hospital's total routine and ancillary costs for a "base year", which in this case was 1974. Routine costs include such items as nursing staff, food service,

maintenance and housekeeping, laundry, social service and administrative expenses; ancillary costs include such items as operating rooms, radiology departments, laboratories and drugs. Once a hospital's total allowable routine and ancillary costs for the base year were determined, such costs were trended forward to 1975 by a factor based on the movement of certain price indices from the general economy (not the hospital industry) and then to 1976 by a different set of general economic indicators which are supposed to anticipate future cost increases in the actual rate year. We do not challenge here the appropriateness of these economic trending factors; the vice in the defendant's new methodology lies in the manner in which the base year amounts for routine and ancillary costs was calculated.

21. In the case of routine costs, a hospital's total routine costs for the base year (1974) were divided by the number of Medicaid patient days as defined by Medicaid for such year and this per diem cost figure was then added to the per diem routine cost figures of all other hospitals in that hospital's group. For reimbursement purposes the state groups hospitals on the basis of certain criteria. The total per diem routine costs of all hospitals in the group were then "averaged" to produce a group of mean or average per diem routine cost figures. In the case of ancillary costs, the same basic method was followed except that rather than divide by patient days, the total amount of ancillary costs were divided by the hospital's total number of discharges per year thus expressing ancillary costs on a per discharge basis. This figure was then averaged with the ancillary per discharge figures of other members of the group in order

to produce a group mean or average per discharge ancillary cost figure. These two figures--the group average routine cost figure and the group average ancillary figure--are ceilings beyond which all of a hospital's routine and ancillary costs, no matter how reasonable they may be, are disallowed.* Thus, if a hospital's actual routine or ancillary costs exceeded the average, they were excluded from its reimbursement rate. In Mount Sinai's case, the imposition of these ceilings force a reduction in Mount Sinai's 1976 rate of approximately $30.00 per diem below its 1976 costs, and $15.44 per diem below its 1975 rate.

22. In effect, in the calculation of routine and ancillary costs, the state defendants treat a group of hospitals as one large hospital irrespective of whether one hospital performs more gall bladder operations than another, has more cancer patients, renders more sophisticated care to coronary patients, has a higher number of intensive care units and so forth. State defendants have assumed that all

---

* Mount Sinai's rate was computed slightly differently because of the completion of the Annenberg Building in 1975. Mount Sinai was reimbursed "retrospectively" during 1975, i.e., on the basis of actual as opposed to projected 1975 reasonable costs. In computing the 1976 rate, Mount Sinai's routine and ancillary costs for 1975 were calculated and were compared with the 1974 averages for the other hospitals in Mount Sinai's group, as trended forward to 1975. The excess of Mount Sinai's routine and ancillary costs over the group averages were disallowed (Mount Sinai's routine costs were over the ceiling by $18.12 per day and its ancillary costs were over the ceiling by $245.04 per discharge) and the balance was trended forward to 1976. This different computation method, however, was no different in its net effect since all routine and ancillary costs over the group average were disallowed.

hospitals are identical and that any costs in excess of the average must be inefficient costs. In point of fact, hospitals vary widely in such aspects as program content, patient mix, geographical location, physical plant, scope and intensity of services and length of stay. Mount Sinai's operating certificate is not simply a certificate to operate a hospital, but instead lists a wide range of separate and distinct services which the hospital is required to provide, services which are not identical to those listed on the operating certificates of other hospitals. A hospital may be completely efficient and yet have costs which exceed those of other hospitals in its group. Although defendants may claim they have allowed for these differences by their grouping criteria, it is impossible to find two hospitals so similar that the costs are identical. I understand that the affidavit of James C. Ingram discusses these factors in detail.

If ceilings are to be used, there must be a factor (as there has been in the past) which takes into account legitimate differences in the services provided by hospitals within particular groupings.

New Programs After the Base Year

23. Since for purposes of computing its 1976 rate, the 1974 group average was used as its base year cost, Mount Sinai's 1976 rate fails to allow for the additional expenses of programs begun during 1975 despite the fact that all of these expenses were approved by the State pursuant to its planning mechanisms prior to being incurred by Mount Sinai

and despite the fact that Mount Sinai was reimbursed for these expenses during 1975.

A. Annenberg Project. The opening of the Annenberg Building described in paragraph 9 above caused Mount Sinai to incur substantial additional costs. First, this new facility required the hiring of 338 new employees. The new operating rooms required 55 new positions, the cardiac surgery intensive care unit 43 and 111 persons were added to the departments of engineering and housekeeping. Utility and maintenance costs also increased substantially following the opening of the new building.

Facilities for such departments as radiology, neurology and cardiology made possible new diagnostic and treatment procedures, thereby improving the quality of medical care, and raised Mount Sinai's ancillary costs. The effect of all these items has been to increase Mount Sinai's per diem costs in 1976 by $14.45.

I emphasize here that the State specifically approved the need for these program increases in advance. From the inception of the Annenberg Project, the New York State Department of Health participated in the planning process and reviewed and approved construction costs, capital costs and the proposed operational budget for the Project. The Annenberg Project was also reviewed and approved by the Health and Hospital Planning Council of Southern New York and by the Hospital Review and Planning

Council. Moreover, in connection with the mortgage financing of the Annenberg Building, the New York State Housing Finance Agency reviewed Mount Sinai's operating budget and obtained from the Commissioner of Health a formal approval of Medicaid reimbursement for all costs connected with the Project (see Exhibit A,) the same costs which have been excluded from Mount Sinai's rate.

The capital costs for the Annenberg Project are not covered by the ceiling and are in fact being reimbursed. It makes no sense for the regulations to provide for payment of the capital costs of a new facility but to deny reimbursement to the Hospital for its operating expenses.

B. In 1975 Mount Sinai opened a new 19-bed cancer unit. The new unit is the focal point for the treatment of adult cancer patients and includes a specially designed protective environment for patients receiving chemotherapy. Mount Sinai has created 55.4 new positions to staff the unit and expenses and ancillary costs have also risen. The total effect has been to increase Mount Sinai's costs in 1976 by $5.28 per patient day.

The budget for the cancer unit, including the staffing levels, was approved by the State Department of Health. Mount Sinai was reimbursed for the program in 1975. Yet, by basing Mount Sinai's 1976 rate on the 1974 average, the defendants have denied Mount Sinai reimbursement for any of these additional costs.

C. Scanner. In 1975, we acquired a computerized, transverse axial scanner (CAT) the operation of which requires a staff of 1 administrator and 7 technicians. The State approved the acquisition of the CAT and a $120,500 annual budget for its operation. $.31 per in-patient day was added to our 1975 rate to reimburse us for this added expense. We will receive no reimbursement for the CAT in our 1976 rate.

D. Within the next month, Mount Sinai plans to open a new 6-bed coronary care unit. On the basis of the budget which the State Health Department has approved for this unit, this unit will add $1.37 per in-patient day to Mount Sinai's 1976 costs.

E. Other New Programs. Mount Sinai has received approval from the State Health Department to open a renal failure treatment center. However, this program cannot be implemented because of the failure of the 1976 rate to include the additional costs.

Clearly, the foregoing costs, approved as reasonable by the State in its planning process, must, by a parity of reasoning, be deemed reasonable for purposes of reimbursement.

Interns' and Residents' Salaries

The State Defendants have arbitrarily refused to reimburse Mount Sinai for more than 90% of the salaries of its interns and residents on the grounds that 10% of their time is devoted to educational activities. The basis for this disallowance is a regulation, 10 N.Y.C.R.R. §86.26

which has never been properly adopted. It was rejected twice by the New York State Hospital Review and Planning Council, which is the only body under New York law empowered to adopt Medicaid reimbursement regulations. The first rejection was in May, the second in June of this year.

Although interns and residents learn a great deal during their years at Mount Sinai, this learning is done in the context of providing patient care and it is for this provision of patient care, not the learning, that they are paid by Mount Sinai. Indeed, it is anomalous to contend that interns and residents are paid for being students. Students are not paid; they pay others for their instruction. In this case, interns and residents "pay" for the training they receive by providing substantial patient care services. Rather than paying for inappropriate costs, the State is receiving a considerable bargain, as is demonstrated by even a cursory review of what interns and residents do.* Interns and residents bear the immediate responsibility for the rendition of care to Mount Sinai's Medicaid patients. Although they attend conferences and rounds, it is for the purpose of discussing cases in the hospital and improving the treatment of patients. An intern at Mount Sinai, who is required to hold an M.D. degree, works approximately 80 hours per week for a salary of $15,400. By any standard, it is obvious that interns and residents are treating patients on a full-time basis.

---

* It is significant that the State Director of the Budget, who has no statutory authority for determining the reasonableness of costs, first disallowed this 10% portion of such salaries and that to my knowledge the State has never made an empirical study of the reasonableness of house staff salaries.

WHEREFORE, it is respectfully requested that the court grant plaintiffs' application for a preliminary injunction.

S David Pomrinse

S. DAVID POMRINSE

Sworn to this 16th day
of July 1976.

Mary Ellen E. McGahan
Notary Public

MARY ELLEN E. McGAHAN
NOTARY PUBLIC, State of New York
No. 31-7827910
Qualified in New York County
Commission Expires March 30, 1978

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients, : 76 Civ. 2027

Plaintiffs, : **AFFIDAVIT**

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U.S. Department of Health, Education & Welfare,

Defendants.

------------------- ----------------------x

STATE OF NEW YORK)
SS.:
COUNTY OF NEW YORK)

IRVIN G. WILMOT, being duly sworn, deposes and says:

1. I am Executive Vice President of New York University Medical Center. I submit this affidavit in support of the plaintiffs' application for a preliminary injunction restraining the defendants from reimbursing any member of the class for hospital services rendered on or after January 1, 1976 at an in-patient hospital Medicaid rate which is less than the rate received by the hospital in 1975.

BACKGROUND OF DEPONENT

2. I graduated from Northwestern University with a degree of B.S. in 1955, and the University of Chicago with a degree of M.B.A. in 1957. I was associated with the University of Chicago from 1947 through 1961 and was an Assistant Administrator of the University of Chicago clinics when I left. Thereafter, I became associated with University Hospital which is part of what is now the New York University Medical Center where I have been since 1961. I have been Executive Vice President of the Medical Center since 1973.

3. I have been a professor of hospital administration at the New York University School of Medicine since 1961. I was previously Assistant Professor of Hospital Administration at the University of Chicago School of Medicine. I am an active member of a number of professional organizations including the American College of Hospital Administrators of which I am a Fellow, the American Hospital Association and the Association of American Medical Colleges. I have, for many years, been active in the Greater New York Hospital Association (GNYHA), as well as the Hospital Association of New York State Incorporated (HANYS). I was President of GNYHA in 1975, have been on the Board of Trustees of HANYS since 1971 and am now its Chairman-elect.

4. I am the author of various articles on hospital administration and am fully familiar with all aspects of hospital reimbursement.

5. New York University Medical Center ("The

Medical Center") is one of the major medical centers in the State of New York. Between the University Hospital ("Hospital") and the Institute of Rehabilitation Medicine, which are components of the Medical Center, it has over 785 beds and provides over 250,000 patient days of hospital service. The Medical Center is considered a "tertiary" medical center and offers facilities and specialized services which are not available at many other hospitals. Patients are referred to the Medical Center from hospitals throughout the United States. In addition, the Medical Center provides general hospital services to the New York community as well as out-patient and medical care through its emergency rooms and the clinics which it operates.

6. Although some of the Medical Center's patients pay the Hospital's established charges themselves, most of the in-patients are covered by conventional insurance, Blue Cross, Medicare or Medicaid. Approximately 85% of the Hospital's operating income is received from Blue Cross, Medicare and Medicaid.

THE INCREASE IN THE HOSPITAL'S COSTS FROM 1975 TO 1976

7. The general inflationary forces to which the entire economy in this country has been subject in recent years is a matter of public knowledge. This Court can take judicial notice of the fact, for example, that the consumer price index in the City of New York rose from 161.1 on January 1, 1975 to 174.9 in May 1976. The wholesale price index has likewise risen from 171.8 on January 1,1975 to 183.1 as of June 1976. Like all institutions, the Medical Center

has been subject to these same inflationary pressures and, despite the fact that we have instituted a vigorous cost reduction program, the Hospital's costs have continued to increase.

8. In 1975, the Medicaid reimbursement rate which the Medical Center received was $225.42 per diem, although the Hospital's actual cost was $251.64. For 1976, the Hospital's estimated per diem cost per patient is $277. However, the Hospital's 1976 Medicaid rate has been reduced to $201.47. Thus, while the Hospital's actual reasonable costs from last year to this year increased by about 10%, its Medicaid reimbursement rate has decreased by more than 10%.

EXAMPLES OF INCREASES IN THE HOSPITAL'S COSTS

9. The Medical Center has experienced the impact of inflation in almost every area of its operations. For example, the Hospital's costs for providing malpractice insurance has increased by 117% in 1976 over 1975. Our actual costs have gone from $429,000 to $932,000. The costs of electricity have increased by 12%; steam by 19.3%; telephone by 35.3%; and food by 3.6%. Our labor costs have increased sharply in 1976 because we operate on a system pursuant to which labor increases go into effect in September or October of a calendar year, and, therefore, increased substantially in September and October, 1975. The costs of pensions, welfare and Social Security payments have increased this year over 1975 by 16.7%.

THE IMPACT OF THE AMENDED REGULATIONS

10. I have been informed that other affidavits submitted in support of our application for a preliminary injunction spell out in complete detail the disastrous effect which the proposed new regulations have on the reimbursement to hospitals for services rendered to Medicaid patients. I assume that the Court has been informed how the ceilings mandated by these regulations limit reimbursement. I shall confine myself to one example of how these ceilings operate to prevent The Medical Center from receiving the reasonable costs of the hospital care which is furnished to Medicaid patients.

11. Our medical-surgical bed occupancy for the years 1974, 1975 and thus far in 1976 has been approximately 5%. For practical purposes, this means that we are running at capacity in the medical-surgical areas. The Medical Center is one of the leading open heart surgery hospitals in the State. In 1974 we treated 849 open heart surgery patients. In 1975 we treated 952 such patients and in 1976 the rate is running about the same as 1975.

12. Open heart surgery is one of the most expensive surgical procedures in a hospital and the figures referred to above establish that by increasing the number of its open heart patients the Hospital has taken on more expensive care patients and has eliminated the treatment of less expensive care patients. Since we have the same number of beds in each year and the occupancy rate is the same, the increase in open heart cases must mean that other, less expensive, cases have been eliminated. Our in-patient records

demonstrate that the cost of maintaining the average open heart patient in the Hospital is about $11,500. The average length of stay for these patients is about 17 days. This means that the Hospital's average per diem cost for these patients is about $675 per day. It is clear that limiting our reimbursement to the average of all hospitals in our group precludes the Hospital from receiving reimbursement for its reasonable costs.

13. I should point out that we have this capacity to treat more open heart surgery cases than we do. We have, however, been forced to limit the number of these patients because we do not have the money to pay for the very high cost procedures involved.

INJURY TO THE HOSPITAL AS A RESULT OF THE CHANGES IN THE REGULATIONS

14. The Hospital's actual reasonable cost of treating patients is estimated to be $277 per day this year. Its Medicaid rate announced by the Commissioner of Health on July 1st is $201.47. The gap between our actual reasonable cost and the rate announced by the Commissioner is 27%. If every other third party payor (for example, Blue Cross) adopted $201.47 as our "reasonable" daily cost, this 27% gap would cause a shortfall to the Medical Center of $15,800,000 for 1976.

15. Such a catastrophe to University Hospital would destroy it as it now exists and reduce it to an institution of a character not even comparable to the Medical Center that has been serving the City. Obviously, this would

be a result that the people of the State of New York simply could not tolerate.

WHEREFORE, it is respectfully requested that the motion for a preliminary injunction should be granted.

IRVIN G. WILMOT

Sworn to before me this
16th day of July, 1976.

Lillian Gonzalez
Notary Public

LILLIAN GONZALEZ
Notary Public, State of New York
No. 31-[illegible]
Qualified in New York County
Commission Expires March 30, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- -x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients, : 76 Civ. 2027

Plaintiffs,

- against - : **AFFIDAVIT**

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

- -x

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

DARRELL G. HARTLINE being duly sworn, deposes and says:

1. This affidavit is made in support of the motion by The Genesee Hospital and the other plaintiffs in this action for an order preliminarily enjoining state officials from reimbursing members of the class for services rendered to Medicaid patients on or after January 1, 1976 at rates lower than those paid in 1975 for in-patient care.

2. I am the Director of Finance of The Genesee Hospital (the "Hospital"), a 427 bed non-profit voluntary health care institution located in Rochester, New York.

Since 1970 I have been the chief financial officer of the Hospital. I received a Bachelor of Science degree in Business Administration from Southern Illinois University in 1962 and have been employed in the field of health care finance since 1965.

3. Like many other health care institutions, the primary source of funds for the Hospital comes from third-party payors like Blue Cross, Medicare and Medicaid. Together, these programs provide 90% of Genesee's in-patient annual income. Reimbursement for in-patient hospital care provided Medicaid patients is governed by federal standards, although the actual calculation of the amount of reimbursement is done by the State. As I understand the federal law, hospitals must be reimbursed for the reasonable costs they incur in providing care to Medicaid patients. New York has an approved alternative method by which this calculation of reasonable cost is made. Briefly, this is done by calculating total allowable costs for a base year. In the case of the 1976 rate, the base year is 1974. The allowable costs are increased by an adjustment or trend factor intended to reflect changes in costs from the base year to the reimbursement year due to inflation. These costs are then divided by the number of days of care provided in the base year to calculate a per diem reimbursement rate.

4. As of December 31, 1975, the Hospital was being reimbursed at the rate of $182.57 for each day of in-patient care it provided a Medicaid patient. Although a new rate was supposed to go into effect on January 1, 1976, it did not. Rather, reimbursement throughout the first 6 months of 1976 was continued at 1975 levels. By a news release issued by the Commissioner of Health dated July 1, 1976, the

Hospital received notification of a rate change which is to be retroactive to January 1, 1976. Instead of receiving $182.57 for each in-patient Medicaid day, the Hospital is to receive $163.38 for the same service. Thus, the Hospital's rate has been reduced $19.19 per day below 1975 levels. Moreover, since the Commissioner of Health has stated that the new rate will be effective as of January 1, 1976, I expect the authorities to attempt to recoup what they will consider to be an overpayment. Since the Hospital provided 5780 days of Medicaid care during the first six months of 1976, I expect that the authorities will seek to recoup from the Hospital $19.19 for each of these days, or $110,918.20.

5. As I will more fully explain below, the new Medicaid rate bears no rational relationship to the costs which the Hospital incurs in providing services to Medicaid patients, nor does it comply with the standard for reimbursement under the Medicaid Act—that is, that the Hospital be reimbursed for the reasonable costs of providing services to Medicaid patients.

6. Approximately 90% of the Hospital's annual census is comprised of Medicaid, Medicare and Blue Cross patients. Under these programs, the Hospital, with minor exceptions, is prohibited from charging covered patients anything in addition to the reimbursement the Hospital receives from these programs for the services rendered. The cost to the Hospital of an average patient day in 1975 was $185.20. I estimate that the same care will cost the Hospital $199.03 per average patient day in 1976. This is an increase of $13.83 or 7.5% per patient day. The Hospital is being asked to accept a 10% reduction in the amount of reimbursement it receives for treating Medicaid patients,

even though its actual costs of providing the same care will increase approximately 7.5%.

THE EFFECT OF INFLATION

7. The Hospital has felt the effects of inflation in every phase of its operations. A sampling of the Hospital's expenses, which is neither misleading nor taken out of context, demonstrates what is happening. A cardiac pacemaker which cost $1,150 in 1974, and $1,250 in 1975; costs $1,525 today. The lead for that pacemaker which cost $150 last year costs $195 today, and, the average cost of one thousand kilowatts of electricity, which was $21.60 last year, is $31.30 today.

8. While the Hospital has not experienced an increase in the number of beds nor any significant change in the number of patient days since 1975, the Hospital's gross expenses have increased significantly since last year. Labor costs for the first five months of 1976 were $8,101,204, compared with $7,332,121 for the comparable five months of 1975. The cost of materials and supplies, which was $5,082,250 during the first five months of 1975, rose to $6,242,117 during the same period in 1976. Due to the occupancy of new state approved Hospital facilities, interest which cost $189,224 during the first five months of 1975, more than tripled to $639,035 for the comparable period of 1976. For the first five months of 1976, the Hospital paid $267,807 for drug supplies, some $43,000 more than it paid during the same period in 1975. Pension costs to the Hospital were $794,243 in 1975. As a result of new federal legislation (ERISA) I expect these costs to rise to $949,700 this year.

9. The Hospital has made every reasonable effort to reduce operating losses, including a reduction in malpractice insurance coverage from $21,000,000 to $1,000,000 and postponement of plant and facility maintenance. Nonetheless, it is inevitable that the Hospital will lose money from operations at an accelerated rate if the newly promulgated reimbursement rates are implemented.

PROJECTED LOSSES

10. The anticipated reduction in reimbursement rates will have a severe impact on the Hospital's cash flow In 1975, the Hospital experienced a negligible positive cash flow. As a result of the anticipated reductions in reimbursement rates, I expect the Hospital to experience a negative cash flow of $310,400 for 1976. The best estimate of the loss I expect will be suffered, based upon the newly promulgated reimbursement rates, current and expected costs, and a total number of patient days similar to last years, is $1,009,480. No institution can expect to survive for many years operating at this kind of deficit. Based upon the number of Medicaid patients the Hospital treated last year, and the difference between the Hospital's projected per diem cost and the new promulgated Medicaid rate, I expect the Hospital will lose $438,994 on Medicaid patients.

THE SHORTCOMINGS OF THE REGULATIONS

11. Like other teaching hospitals, The Genesse Hospital incurs substantial expense for its house staff (interns and residents). I am advised that the new regulations allow for reimbursement of only 90% of the costs

incurred in providing house staff coverage. In past years the Hospital was reimbursed 100% of these costs. My lawyers tell me that the Commissioner of Health claims this new regulation is based on a provision in the Public Health Law that excludes from reimbursement those costs for educational activities not directly related to patient care. These interns and residents, each of whom works an average of 70 hours per week, perform a variety of patient care functions which help to discharge the Hospital's obligations to its patients. The exclusion of a portion of the cost of interns and residents makes no sense to me since we pay our interns and residents to treat our patients; we are not paying them to be educated. The is not to deny that interns and residents learn as they treat our patients.

12. The regulation places an impossible burden on the hospital since no economies are possible which would enable us to break even on the costs incurred for house staff. This is because the regulation allows reimbursement for 90% of anything the Hospital pays, not 90% of a fixed dollar amount.

13. As I understand the purpose of the New York law, it is designed to encourage economical hospital operation. I do not see how the reduced reimbursement for interns and residents will promote this goal. The regulation will have the effect of forcing the Hospital to reduce its staff of interns and residents to minimize losses and to hire full time doctors to fill the void left. Each full time doctor hired to replace an intern or resident will cost the Hospital at least twice as much as the person replaced.

ROUTINE, ANCILLARY, AND BASE YEAR (SECTION 86.21(k)) CEILINGS

14. In addition to providing basic health care services for the general Rochester community, the Hospital provides a number of special, and in some cases unique services. For example, we have an extremely sophisticated gastro-intestinal care unit. I am informed by the Chief of that Department that the services we provide are duplicated by no more than 1 or 2 hospitals in the country and that our gastro-intestinal facilities save lives that would be lost at hospitals without our expertise. Thus, hospitals from throughtout the Greater Rochester area, as well as Upstate New York, routinely refer patients to us for gastro-intestinal treatment. Our cardiology department is a leader in the field, and we are fortunate enough to have a world renowned expert on pacemakers on our staff. We have what may be the most sophisticated computer assisted laboratory in the area, and are a reference laboratory for the New York Department of Health. We treat 50% more cancer patients than the national average for general hospitals, and perform vital end-state renal disease procedures, including dialysis to patients with kidney malfunctions. In addition, we are affiliated with the University of Rochester School of Medicine and Dentistry and have 70 interns and residents on our staff.

15. I am informed that the operation of the routine and ancillary ceilings is described in detail in the affidavit of James C. Ingram. The services described in the above paragraph are examples of the kinds of specialized intensive cost services which increase the Hospital's ancillary costs and which make the imposition of ancillary cost ceilings unreasonable.

16. It is my professional opinion that these new regulations deprive the members of the class of the reimbursement to which they are entitled if they are to recoup their reasonable in-patient costs. It is unfair and unjust to expect Genesee to conform its expenditures to these ceilings which operate blindly, without any reference to the natural differences in the types of service different hospitals offer. These differences cause some hospitals in a group to experience higher, but reasonable, costs when compared to other hospitals.

17. Even if it were possible for the Hospital to borrow money to meet its operating costs and cash flow problems described above, the Hospital would nonetheless be irreparably injured by the operation of Sec. 86.21(k). Any hospital which could borrow money would incur substantial interest expenses which it did not have in 1975. By operation of Sec. 86.21(k) any expense not experienced in 1975, including such extraordinary interest expenses, could not be included in reimbursable costs in 1978 and thereafter.

18. If the voluntary hospitals in this State are to survive and if the public interest in providing health care is to be vindicated, the injunction prayed for should be issued.

WHEREFORE, it is respectfully requested that the Court grant plaintiffs' application for a preliminary injunction.

Darrell G. Hartline

Darrell G. Hartline

Sworn to before me this
16th day of July, 1976.

Robert M. Kaufman

Notary Public

[illegible] FMAN
NOTARY [illegible] State of Ne[illegible]
No. [illegible]
Qualified [illegible]

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

--------------------------------- x
:
HOSPITAL ASSOCIATION OF NEW YORK :
STATE, et al., :
:
Plaintiffs, :
:
vs. : 76 Civ. 2027
:
PHILIP L. TOIA, as Commissioner :
of Social Services of the :
State of New York, et al., :
:
Defendants. :
:
---------------------------------x

Before:

HON. MORRIS E. LASKER,

District Judge.

New York, July 20, 1976,
10:45 a.m.

APPEARANCES:

PROSKAUER, ROSE, GOETZ & MENDELSOHN, ESQS.,
Attorneys for Plaintiffs
BY: JACOB IMBERMAN, ESQ.,
SUSAN ROSENFELD, ESQ.,
M. WILLIAM SCHERER, ESQ., of Counsel

LOUIS J. LEFKOWITZ, ESQ., Attorney General of the State
of New York
Attorney for Defendants
BY: JESSE J. FINE, ESQ., Assistant Attorney General

DAVID MATTHEWS, Secretary, United States Department
of Health, Education and Welfare
BY: ROBERT B. FISKE, JR., ESQ., United States Attorney
for the Southern District of New York
BY: JOHN M. O'CONNOR, ESQ., Assistant United
States Attorney

THE CLERK: Hospital Association of New York State and others against Philip L. Toia.

Plaintiff ready?

MR. IMBERMAN: Plaintiff is ready.

THE CLERK: Defendants ready?

MR. FINE: State's defendants are ready.

MR. O'CONNOR: Federal defendants are ready.

THE COURT: As you know, gentlemen and lady, this hearing was called for the purpose of allowing parties to put on whatever testimony they wish to supplement the papers that have been filed in the application for preliminary injunction by the plaintiffs, and I'm ready to hear the witnesses.

I haven't received, Mr. Fine, any answering papers yet. Will I get those today?

MR. FINE: No, your Honor, you will not. May I explain to your Honor, I should like to make it very clear, I received Mr. Imberman's papers, the plaintiffs' papers, on Friday afternoon.

THE COURT: Yes.

MR. FINE: And by the time I got back into the office, to my office, from the conference in your chambers it was really too late to dig much up, or to even prepare papers or affidavits for any of my hospital officials.

I conferred with them all day yesterday, we are in court today, and I would respectfully ask that I have at least until Friday to submit an answering affidavit or papers, or perhaps, if the case develops to that extent, put some of my people on the stand.

You will recall that your Honor reserved both today and Friday for the hearing of this case.

THE COURT: I did, although it is my ardent hope that we will be able to conclude whatever live testimony we need today.

MR. FINE: It is mine, too, but I also respectfully ask that I be permitted to submit an answering affidavit by Friday.

THE COURT: Oh, certainly.

MR. O'CONNOR: Your Honor, excuse me. Before the witnesses are called I would like to make a brief statement to the Court with regard to the federal defendants' position.

The last pretrial conference,which spoke about federal defendants supplying a currently-approved version of the state plan, I have with me today an attachment to a state plan. It is called attachment 419-A, and this is not the entire state plan, but it is that portion of the state plan which deals primarily with the reporting of rate certification, which is primarily the matter in conference. I have supplied a copy of this to both plaintiffs and to the state defendant and it is ready here. I just want to state on the record that we have supplied this to both counsel as requested at the last pretrial conference.

Now, also, with regard to this attachment 419-A, as federal defendant represents, this is the currently-approved version of the state plan as of this date. It is that portion of the state plan that applies primarily to the setting of rates. There have been amendments proposed to this. These amendments have not yet as yet been approved, so the portion of the plan that I've supplied to both counsel is what is presently and currently the approved version.

Finally, as I mentioned before, your Honor, it is the federal defendant's position that there is no subject matter of jurisdiction over the federal defendant. The relief asked, as I understand, is mandamus relief, and it is our position that this is discretionary and therefore the court should not mandamus the

Department of Health, Education and Welfare.

THE COURT: It may be discretionary but that doesn't beat the jurisdictional question, does it?

MR. O'CONNOR: Well, your Honor, I just wanted to state that we don't believe that mandamus is appropriate in this case and we will be filing motion papers in that regard.

And, finally, in light of the fact that we don't feel that we are properly defendants in this case, and in light of the fact that plaintiff has not asked any temporary relief against the federal defendant, we don't anticipate participating any further in the hearing than what we have already done this morning.

THE COURT: Well, from what I gathered from our discussion on Friday I don't think it will be necessary for you to participate. I don't know if you want to attend or not.

But, Mr. Imberman, do you intend to introduce any material which you think Mr. O'Connor may wish to have --

MR. IMBERMAN: If your Honor please, I do intend to introduce the state plan as it has been adopted.

THE COURT: The one that has already in

the past been approved?

MR. IMBERMAN: Yes, sir.

THE COURT: I thought he said he's presenting that.

MR. IMBERMAN: No, because, your Honor, what Mr. O'Connor was referring to was an attachment to the state plan. I will at the appropriate time offer the plan itself, and then the current attachment which relates to the rates and rate-fixing so that the record will be complete.

THE COURT: Fine. But in any event, there's nothing adverse in that to the government's position, is there?

MR. IMBERMAN: No. As a matter of fact, I appreciate very much Mr. O'Connor's statement that as far as the United States is concerned the amendments, which are in part the subject matter of this litigation, have not been approved.

THE COURT: I assume that that's stipulated, is it not, Mr. Fine?

MR. FINE: Yes, that's stipulated, your Honor, but I wondered if I could ask your Honor to direct the U. S. attorney to submit to the court the copies of the proposed amendments which were submitted to the

Department of Health, Education and Welfare for approval and which are now pending before the department. I think that would fill in the picture.

MR. IMBERMAN: Your Honor, may I ask that we take this in order and let the plaintiff present its case before we get to that?

THE COURT: Yes. Sooner or later obviously, however, I will want to know what the status is of the amendments whether they have been submitted or not.

Mr. Fine, as far as I'm concerned I'm prepared to accept that documentation on your representation that they have been submitted for approval and I think even Mr. Imberman -- I say "even" --

MR. IMBERMAN: If Mr. Fine hands up certain documents and says these have been submitted I will accept his word.

MR. FINE: As a matter of fact, your Honor, I'm going a step further. I'm asking the United States attorney to hand up what has been submitted.

THE COURT: Have you got them, Mr. O'Connor?

MR. O'CONNOR: Yes, I have.

THE COURT: All right, fine.

MR. IMBERMAN: Your Honor, may I respectfully ask that these be handed up at the appropriate time so it fits into the presentation of my proof.

THE COURT: We can use them in evidence at that time but let's mark them and know that we have got something from Mr. O'Connor here.

MR. IMBERMAN: Then if that is the case, your Honor, I would suggest that there be first marked the state plan itself which I would offer as Plaintiffs' Exhibit 1, which is the document which I'm handing up now.

(Plaintiffs' Exhibit 1 was marked for identification.)

MR. FINE: Mr. Imberman, may I see it?

MR. IMBERMAN: Yes, of course.

THE COURT: Call it Government's Exhibit 1.

MR. O'CONNOR: Yes. This will be Federal Defendant's Exhibit A, and this Exhibit A is an attachment to 4.19-A, dated April 1, 1974 and entitled "Reporting and Rate Certification for Medical Facilities."

And as Federal Defendant's Exhibit A2 --

THE COURT: Why A2, why not B?

MR. O'CONNOR: B, excuse me -- is a proposed change that has been submitted to the Department of Health, Education and Welfare on behalf of New York State, and this application for approval of a change is entitled"75-60, Plan Amendment 75-60."

THE COURT: Do you know what date it was submitted? Is there any indication?

MR. O'CONNOR: There is a transmittal date. I do not know if that's the date that --

THE COURT: What's the transmittal date?

MR. O'CONNOR: 12/17/75.

THE COURT: That wouldn't be the document that Mr. Fine is talking about, would it? Because I assume that whatever Mr. Fine is talking about that's been submitted to me that is relevant to me now is the regulation or the amendment or whatever that was approved in the last week or 10 days.

Do you have anything?

MR. O'CONNOR: We do not, your Honor. These are plan amendments that have been submitted.

A second of these would be Government's Exhibit C, 75-61.

THE COURT: Also a proposed change?

MR. O'CONNOR: Yes, a plan, a proposed plan amendment, and the transmittal date -- this is just for identification purposes -- is 12/17/75.

THE COURT: All right.

(Federal Defendant's Exhibits A through C were marked for identification.)

MR. O'CONNOR: And Federal Defendant's Exhibit D for identification is a proposed plan amendment marked 75-62, with a transmittal date, for identification purposes, of 12/18/75, and copies of these have been supplied to both the plaintiff and to the state defendant before the hearing this morning.

(Federal Defendant's Exhibit D was marked for identification.)

MR. IMBERMAN: Your Honor, I might just comment I just had a chance to scan these things briefly but I don't think anything that Mr. O'Connor has just offered relates to the specific regulation we are talking about.

THE COURT: They have all merely been marked for identification.

MR. IMBERMAN: All right.

THE COURT: Now you have the floor.

MR. IMBERMAN: If your Honor please, if I may be permitted a brief opening statement just to put this case in context.

What we have here is a motion for a preliminary injunction in this class action brought on behalf of the voluntary hospitals of the State of New York for the purpose of maintaining the status quo.

During the year 1976 and up until July 1st the voluntary hospitals were being reimbursed by the state government for services rendered to Medicaid patients at the 1975 rate. This was, in effect, nothing more than a freeze of rates and as our brief shows was patently illegal.

On July 1, 1976, in my opinion, if I can use a phrase, something even more illegal occurred because at that time the Commissioner of Health promulgated the various regulations to which we have referred in our papers and announced Medicaid reimbursement rates retroactive to January 1, 1976 based on these rates. And the regulations are illegal because, as has been conceded here in open court, they have never been approved by the federal government, by the Department of HEW, and the rates which are produced by these regulations are just as illegal, because as the affidavits which we have supplied and the testimony will show they do not produce reimbursement rates to the hospitals which supply the hospitals with the reasonable cost of producing the service. And I would suggest that this problem of reasonable cost would be highlighted when Dr. Pomrinse of Mt. Sinai Hospital, who is here, testifies, and Dr. Pomrinse will tell your Honor that the 1975 rate at Mt. Sinai Hospital --

THE COURT: You don't need to tell me what he is going to tell me. Because first of all, I read the excellent affidavits which were attached to your papers; and, secondly, I will hear it from him.

MR. IMBERMAN: I think what is focused by the Mt. Sinai testimony is that we now have specific projects approved by the State of New York in advance but we don't have the money to pay for them because the costs that Mt. Sinai is getting are reduced.

And I would like to also suggest to your Honor, because I think the one time in chambers your Honor seemed to consider that this government approval was just a technical requirement; it is not.

THE COURT: No, let me say that having read the papers I understand the importance of it in a way that I did not understand it at the time that I may have created that impression. I no longer think it is a very --

MR. IMBERMAN: Thank you. And the cases which we have referred to in our brief make it very clear that preimplimentation approval is an absolute necessity.

The new rates are also unlawful because they do not produce the amount of money necessary for the hospitals to have a reimbursement for the services which they provide. And the Court of Appeals, your Honor, has had occasion to speak on this subject twice, and I am sure your Honor is familiar with both the Catholic Medical Center case and the Connecticut case.

THE COURT: Since Sunday afternoon I am.

MR. IMBERMAN: And because during the course of our discussion in chambers one day your Honor raised the question as to what is really meant by reasonable costs, how do you determine what reasonable cost is, and as any court spoken to it. And think a careful reading of the Connecticut case demonstrates that the Court of Appeals in this circuit has indeed spoken, because at one point the court says the following. I'd like to read for just a second, and I'm quoting now:

"The Social Security Act provides for payment of the reasonable cost of inpatient hospital services provided under the plan. The Secretary has intepreted this to mean payment of approximately the actual cost of the services provided."

"The actual cost of the services provided." This interpretation is reasonable and in accordance with the intent of Congress.

And then there is a very interesting footnote in that opinion, where the court again addresses itself to its very point, footnote 2, and I read this. I quote:

"Although payment may be made on various bases, the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost, both direct and indirect, of the services rendered to the beneficiaries of the program."

Now, it seems to me that nothing could be clearer than that language, and it seems to me that when the government starts paying at rates which are less than 1975 rates a third of the hospitals in the state you just are not reaching what the Court of Appeals said the hospitals have to receive.

I'd like to make one other point before I put my witnesses on, your Honor. The voluntary hospitals of this state do not live in a vacuum. They are all over the state, in every city, in every community. The boards of trustees that run the hospitals are people who live in the community. They are keenly aware of the financial problems of the state, of the city, and of their own communities, and they have done and are doing everything possible to economize and to live within the unfortunate requirements of the present day.

On the other hand, you are dealing here with the great providers of health care to people of this state, and the state has mandated that the highest quality of health care is essential to the people of New York, and the state has encouraged these hospitals to provide such high-quality service, and what has happened is these institutions are caught in the vise of increasing costs for everything that they must purchase and over which they have absolutely no control, on the one hand, and the financial strictures of the state on the other, and something just has to give.

The pressure on hospitals is great, and I would suggest the injury today will be irreparable unless your Honor grants this injunction.

THE COURT: Mr. Fine, did you want to

say something?

MR. FINE: I just wanted to make one observation about Mr. Imberman's reference to the requirement the hospitals be paid reasonable costs. If your Honor will recall, the Catholic Medical Center case dealt with a statutory freeze by which the legislature froze the Medicaid rates for the period beginning at about March, 1969 to the end of 1969. That was because the State of New York had previously adopted a technique for fixing a ceiling on hospital Blue Cross and Medicaid rates prospectively, setting the rates in advance, and what the court held in that Catholic Medical Center was that this violated the Social Security Act and the regulations promulgated thereunder. Thereafter the Commissioner of the Department of Health, Education and Welfare approved the New York State plan of prospective rate-setting.

In other words, Mr. Ingram, Mr. Imberman's expert in this field, says in his own affidavit, and I think I will quote:

"In the approved state plan, New York has agreed to reimburse hospitals the reasonable cost of providing inpatient care to Medicaid patients."

The method by which a hospital's reasonable cost is reimbursed is also part of the state plan. This method was specifically approved by the Secretary when he approved the plan. This method is what is known as prospective rate reimbursement method.

I think the key to an understanding of what the state is doing here is not attempting to reimburse the hospitals for their actual costs, but is carrying out the state's desire to tell the hospitals in advance "This is our ceiling, this is as far as we go. If you can keep your costs below that ceiling and profit by it, so much the better. If your costs exceed -- if the rate of reimbursement we have prospectively set exceeds your costs, that's too bad. But we have to have some technique of controlling the constant escalation of hospital costs.

Now, I've conceded that the state -- recent state amendments to the plan have not been approved. They were submitted I think roughly between the first of the year and perhaps thereafter. The Department of Health --

THE COURT: I'm a little confused. I thought that the critical material had not been finalized by the state itself until 10 days ago?

MR. FINE: There are three regulations

which Mr. Imgram and the plaintiff attack. One deals with a provision in the state regulation, newly adopted, I think adopted as late as June or July, which limits the percentage of interns and residents' costs which may be allocated as part of the hospital's operating cost.

THE COURT: Ninety per cent.

MR. FINE: Deduct 90 per cent.

The other two have to do with the whole, overall rate-making procedure. Those were submitted I believe some time perhaps in January to the Department of Health, Education and Welfare.

Now, technically under their own regulations HEW, I think regulation 203, is supposed to act on those amendments to a state plan within 90 days, but where there are negotiations going on between HEW and the state about these new amendments there is an agreement that time may be extended. I believe that HEW is pretty nearly on the verge of approving the new amendments to our plan retroactively.

Now, the main thrust of my argument to your Honor today is this: It is mostly true that the new amendments have not been approved by HEW, and perfectly true under that New Jersey case,. with which your Honor is familiar, and assuming that your Honor is of the opinion to follow that case, that the fact of non-approval means that those new amendments, they not be implemented, but I submit to your Honor that the same situation obtains here as obtained in that New Jersey case: there is no irreparable damage to the hospitals. The cash flow to them is being continued. If ultimately on the plenary hearing and after plenary trial --

THE COURT: You mean the revised cash flow. The revised cash flow.

MR. FINE: Now, let me explain to your Honor something about that. Even Mt. Sinai, one of our largest hospitals in the city, in the State of New York -- and I'll expand on this a little later -- says that it's loss for the calendar year I think will be in the neighborhood of $2 million. I would guess that Mr. Sinai's overall budget must run close to somewheres over 50 and 100 million dollars. And if Mt. Sinai is affected so little I say to you that the smaller hospitals throughout the state are affected even less.

What I am trying to argue, and I will demonstrate to you by affidavit, that all-over damage to the hospitals which they would claim is the basis for their preliminary injunction is not irreparable, there is no damage to --

THE COURT: I think that argument cuts both ways. Frankly, it is not irreparable to the state either.

MR. FINE: Well, the state doesn't have the money. You know there is the real thrust, your Honor, of this whole thing. And I want to tell you in the Catholic Medical Center case the impact on the state's budget was considered.

THE COURT: What will the state do if this court or the Court of Appeals rules against it?

MR. FINE: I have a suspicion your Honor that they will further curtail the extended variety of Medicaid services. They have some options.

THE COURT: That may have to happen. I mean, when push comes to shove, something has to give, as the gentleman says. But the question is not really the question I have to decide. The question I have to decide is what are your legal obligations?

MR. FINE: I represent to your Honor -- may I just get a document that I want to -- I want to give you the statics on this.

THE COURT: I'm awfully anxious to get

to hearing witnesses, which is the reason I called this meeting.

MR. FINE: I will defer my argument till later.

THE COURT: I think that will be better. I'd like to hear what witnesses have to say. Lawyers can always get together with me.

JAMES C. INGRAM, called as a witness by plaintiffs, being first duly sworn, testified as follows:

THE COURT: Mr. Ingram -- first of all, I want to kind of permit you both whatever your respective responsibilities and credits are for Mr. Ingram's affidavit to date.

Secondly, I note he's taking a copy of it here with him to the stand.

MR. IMBERMAN: Just to refer to some statistics.

THE COURT: Sure, I can understand that. I only wanted to ask that we don't merely have a repetition of the affidavit in testimony, because I assure you I have read it, I understand it, and I've absorbed its contents. It is good to have Mr. Ingram here so that Mr. Fine can ask him any questions he wants to.

MR. IMBERMAN: I will try to limit Mr. Ingram's proof as much as possible. On the other hand, your Honor, this is a rather technical area and I wanted your Honor to have the benefit of the give and take of the expert.

THE COURT: I'm glad to have it. I just wanted to explain that I do understand what I've received so far.

MR. IMBERMAN: Before I get to that, your Honor, there were certain stipulations that Mr. Fine was gracious enough to make and I want to make sure that we have these on the record.

In addition to the one that the amendments to the plan relating to the three regulations to which we refer, 86.14B, 86.26 and 86.21K, have not been approved by HEW, Mr. Ingram has -- Mr. Fine has also stated that 86.26 has not been approved by the State Hospital Review and Planning Council, which I submit to your Honor is required by law, and that that same regulation has not reposed for 21 days with the temporary President of the Senate and the Speaker of the State Assembly, which is also required by law in this case, Section 1018 of the Executive Law.

In addition, Mr. Fine has been gracious enough to inform me that the state will not introduce any evidence to controvert the affidavits of Irving Wilmott, the the executive vice president of New York University Medical Center, and Darling Hartline, the director of finance of the Genesee Hospital in Rochester, New York. Both of these affidavits have been filed in support of our motion.

Now --

MR. FINE: Excuse me, your Honor. Would you hear me for just one moment, because I want to make very clear the extent of my stipulation with respect to regulation 86.26.

THE COURT: Yes.

MR. FINE: I concede the fact that it was not approved by the Public Health Commission. I concede the fact that before it was put into effect it was not for 21 days before the Speaker of the House or the Speaker of the Senate of the State of New York, but do not concede that either of these statements invalidate the regulations because I believe that there is sufficient legal justification to be upheld.

THE COURT: I did not assume that you did concede that they were invalid but only the facts that they hadn't been approved.

MR. IMBERMAN: That's right, and that's the New York State Public Health Council.

THE COURT: Whatever it is named.

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q Mr. Ingram, what is your occupation?

A I am a principal in the financial consulting-firm of Ingram, White & Berkins Co., Inc.

Q In what field are they consultants?

A Hospital finance.

Q And were you an officer of Blue Cross and Blue Shield of Greater New York for some 20-odd years before you went into this new business?

A I was an officer of Blue Cross, beginning in 1956 as assistant vice president, I was appointed a vice president in 1967.

Q And what were your duties primarily related to?

A I was vice president for provider reimbursement. My function was to set the level of reimbursement for Blue Cross and for the Medicare program. That is, for those hospitals that chose Blue Cross as the fiscal intermediary.

Q And for how many years did you occupy that position?

A From 1961 through --

MR. FINE: To save time I will concede Mr. Ingram's expertise.

MR. IMBERMAN: Fine.

Q Then I ask you just one further question: are you also a consultant to the Social Security Administration in the field of hospital reimbursement?

A Yes, I am.

Q For how many years have you been a consultant?

A Oh, in various capacities on and off since 1966.

Q Have you as a result of your activities become familiar with requirements of the Medicaid law and the Medicaid regulations insofar as they relate to hospital reimbursement?

A Yes, sir.

Q And could you tell us briefly just what they require as far as hospital reimbursement is concerned?

A The law requires that hospital inpatient services be reimbursed on the basis of reasonable costs. There is no requirement in the law that I know of that refers to anything but hospital inpatient services.

The implementation of the law has always been understood to have been the regulations adopted for the Medicare program, except insofar as they might vary when a state submits a plan of reimbursement which would, in effect,produce the same result.

Q Are you familiar with what is called Part 86 in the State of New York?

A Yes, sir.

Q What is Part 86?

A Part 86 is the Commissioner of Health's rules and regulations to be used by the state in establishing Medicaid rates of payment and permitting Blue Cross plans in the state to establish reimbursement methods not inconsistent with and virtually similar to the rules and regulations used to establish Medicaid rates of payment.

Q Now, are you also familiar with the prospective reimbursement system in effect in New York?.

A Yes, I am.

Q And when did that become effective in New York?

A January 1, 1970.

Q And prior to that date were hospitals paid on the basis of the retrospective reimbursement?

A Yes, sir.

Q Did that mean that costs were found after the hospitals rendered the services and they would get substantially what they had expended?

A Yes, sir.

Q And prospective reimbursement? Would you explain to the court how that works in New York? Or at least up until the end of 1975 how it worked.

THE COURT: Excuse me. Before you do, what date did you say it became effective?

THE WITNESS: January 1, 1970, your Honor.

THE COURT: All right.

A Hospital costs are determined in the most recent year for which data is available. That year is called the base year. For 1976 the base year would be 1974.

THE COURT: Is that simply because in accordance with the plan you picked two years before?

THE WITNESS: No, your Honor. It's a matter of mechanics. It's the only data you have available.

THE COURT: I see. In other words, you don't have the '75 data.

THE WITNESS: Exactly. The rates have been established in the year '76. This means you do in '75, and the only data you have is 1974.

A Prior to 1976 that data was only analyzed on a desk-audit basis for reasonableness, for completeness, for various tests that could be made to assure that it was reasonably valid, again wholly subject to field audit eventually.

A parameter was established by the state limiting per-diem routine service costs to 110 per cent of the average per-diem routine service costs for a group of comparable hospitals.

Blue Cross had something similar. Blue Cross limited base-year costs to 115 per cent of total per-diem costs for a group of comparable hospitals. The base-year costs then having been established either on the actual basis or the maximum allowable, a trending took place for the intermediate year, in this case 1975, and for 1976.

Q What was the purpose of the trending? What did it take into account?

A The state trended for two years based on economic conditions in the area in which the hospital was located. Blue Cross used a trend factor for the intermediate year based on actual costs incurred, again with parameters based on a group of comparable hospitals, and then trended only for the rate year, that is, for 1976, based on an estimate of what economic conditions would be in the area in which the hospital was located.

THE COURT: The word "trend" as used here, it's a term of art, I take it, in your particular line of work?

THE WITNESS: Yes, sir.

THE COURT: Equivalent to a projection of some kind?

THE WITNESS: It's a projection based on index, your Honor.

BY MR. IMBERMAN:

Q Do I take it the trending from '74 to '75 was supposed to take care of the increase in costs that the hospitals had in '75 over the base year?

A On the state level, no. It was supposed to take care of the increase in economic conditions, not particularly applicable to an individual hospital, but economic conditions.

Q General economic conditions?

A In the area in which the hospital was located.

THE COURT: You mean the increases in cost had been caused by general economic conditions?

THE WITNESS: Yes, that's right.

Q The trending from '75 to '76 was to take care of the expected changes in economic conditions during the rate year?

A Yes, sir.

Q Of course, all of this would be done in 1975, am I right?

A That's correct.

Q Now, what you have just described is the system in effect under the approved state plan, that is, the state plan filed and approved by HEW, is that correct?

A Yes, sir.

Q Now, you used the term "routine costs." For the record, would you please explain what orutine hospital service costs are?

A Routine services in the hospital are those services that are generally supportive of the patient. It's the food the patient eats, the environment, the lodging, the linen on the bed, it includes nursing services, it includes medical records, it includes the services of the house staff, the interns and residents, the services of the social service department, if the patient has to be in an intensive care unit or a coronary unit, it includes those services.

It is distinguished from the ancillary services, the ancillary departments are those departments where something happens to the patient. He is operated on, a diagnostic radiological examination is made or laboratory tests are made, or he receives physical therapy modalities or that type of thing.

Q Now, you described before that in the rate-making process hospitals were grouped. Would you please explain for the record how hospitals were grouped and what the purpose of the grouping was?

A The state used -- uses one method, the Blue Cross plans use a different method. Generally speaking, the two methods were compatible with each other.

The purpose was to bring together a group of hospitals that were comparable in size, location and scope of services. The only reason for grouping was to determine those hospitals whose costs were aberrant.

Q You mean extraordinary?

A That is, those costs which exceeded established parameters.

Q Now, in connection with the rate-making process you mentioned before that the state established a ceiling with regard to routine service costs of hospitals in a group. Would you please explain how that worked and what the purpose was?

A The routine cost was determined for each hospital in total. A schedule is prepared showing for that cost the name of the hospital, the number of patient-days and its total routine costs. All of the hospitals within the group to which that hospital was assigned were listed similarly, totals were taken of the patient-days and costs and an average was struck.

The state used one form of centering concept to eliminate the extremes at the top and the bottom. Blue Cross used a different kind of centering concept to accomplish the same thing.

Q What did the state do for Medicaid?

A As I understood prior to this year the state eliminated per-diem costs that exceeded 125 per cent of the average or that below 75 per cent of the average.

The Blue cross used a different percentage but the effect was the same. The revised average, that is, with the extremes on both sides up and down eliminated, was computed and then any hospital whose per-diem routine costs exceeded that revised average at 100 per cent, that 110 per cent of the revised average, their maximum allowable costs became the --

Q Ceiling?

A -- the ceiling.

Q Of 110 per cent, is that correct?

A And of course the purpose of the whole exercise was to eliminate aberrant costs, aberrantly high costs.

Q Now, what was the function of the use of 100 per cent of the group average as a limitation?

A Well, I can't tell you from the state's purpose, but I was doing this for Blue Cross at the time, and had been doing it since 1961, and I assume that the state had the same experience. When we would group comparable hospitals we would find that costs tended to cluster right around the average or the median, and that once you get beyond 110 per cent of routine service costs or 115 per cent of total per-diem costs, including ancillary, you were really dealing with hospitals that were in some form of aberrant situation for one reason or another.

Q So that the 10 per cent was really leeway for the differences in the actual cost of a particular hospital, and within the 10 per cent the state felt that was permissible, is that correct?

A Yes, sir, that's correct.

Q And Blue Cross used 115 per cent of routine ancillary?

A Correct.

Q And am I correct when I say that Blue Cross felt that of these total costs 15 per cent was a reasonable expectation to have, but anything above 15 per cent would not be allowed?

A That's correct.

THE COURT: Am I correct in understanding that Blue Cross' experience is relevant only as to comparison, it is not part of the case?

MR. IMBERMAN: Yes, sir, it is not part of the case, but because they really pay for pretty much the same thing it is relevant.

MR. FINE: Your Honor, I just want to say that I don't know that the testimony as to what Blue Cross assumed or deemed appropriate is relevant here at all and I really object to it.

THE COURT: I am not ruling that it is

relevant. I don't think either of you want to interrupt much when we have no jury and so forth, but I was trying to be sure that it was not part of the case.

BY MR. IMBERMAN:

Q Now, Mr. Ingram, you are familiar, are you not, with the method by which Medicare reimburses hospitals?

A Yes, sir, I am.

Q That is a program which is run by the federal govenment, am I right?

A That's correct, sir.

Q And the federal government pays the hospitals for taking care of Medicare patients?

A Yes, sir.

Q Now, does the federal government under the Medicare system have a type of ceiling limitation that you have just referred to?

A That I have had a limitation since July 1, 1974 on allowable routine-service per-diem costs.

Q And how does the Medicare system operate?

A The hospitals are grouped primarily by bed sizes and whether or not they are located within a standard metropolitan statistical area or not.

That is, generally speaking, whether they are in a rural area or a metropolitan area, and which metropolitan area they are in.

I understand now on July 1st, since July 1st of 1976, these are called standard consolidated statistical areas instead of standard metropolitan statistical areas.

The hospitals within a standard statistical area are arrayed on the basis of their per-diem routine costs with the highest cost hospital at the top and the lowest cost at the bottom, and tehy run from high to low in descending order. The median is calculated and the 80th percentile is calculated. A ceiling is established on the basis of the 80th percentile, plus 10 per cent of the median routine per-diem -- routine-service per-diem cost.

Q Now, are you aware of the freeze of Medicaid reimbursement rates which occurred in the State of New York starting January 1, 1976?

A Yes, I am.

Q And are you also familiar with the new regulations which were promulgated by the Commissioner of Health as of July 1, 1976, or approximately that date? And I'm talking about what's attached to your affidavit as Exhibit A

A I'm not sure of the date, Mr. Imberman. 86.14B I understand was approved by the Hospital Council in April of this year. I don't know when 86.21K and 86.26 -- well, 86.26 has not been approved; I don't know when 86.21K was approved. I am familiar with these three regulations, yes, sir.

Q Do you know Mr. William McCann?

A Yes, I do.

Q Do you know what his title in the State Health Department is?

A He is assistant commissioner of health, primarily charged with the level of reimbursement for Medicaid and enforcing the regulations with respect to Article 9(c) corporations or Blue Cross plans.

Q All right. Is Mr. McCann in the courtroom here?

A He is, yes, sir.

Q And do you know a gentleman named Donald Davidoff?

A Yes, sir, I do.

Q And is he also an official in the State Department of Health?

A He is an associate director of the Bureau of -- they have changed the title and I may not have it correct -- Health Care Cost Control, I think it is.

Q All right.

Did you have occasion to meet with these gentlemen on or about June 22, 1976?

A Yes, I did.

Q Where did you meet with them?

A In the Holiday Inn in Newburgh.

Q And who else was present at that meeting?

A For the hospital side, Mr. Edward Mishay, Mr. Edward Birnbaum, Mr. Marvin Rushkoff. Representing the state, Mr. Robert Schiffer, Mr. Robert Hall from the State Insurance Department, Mr. Leo Margolis from the State Insurance Department, Mr. McCann, Mr. Davidoff, and I am not sure whether there was somebody else present. If I had my notes I could.

Q I think for our purposes that's sufficient.

Was there a discussion at that meeting between you, Mr. McCann and Mr. Davidoff about these new Part 86 regulations which are the subject matter of this lawsuit?

A Yes, sir, there was.

Q And did Mr. Davidoff say anything to you about what the objective was as far as the state was concerned in introducing these new regulations?

A Yes, sir, he did.

Q What did he say?

A He said that the purpose of the new regulations was to cut back on the state outgo to hospitals.

Q To cut the amount of money the state was going to pay the hospitals?

A That's correct, sir.

Q Was there any discussion with regard to the effect that such cutbacks would have on the reasonable cost reimbursement which the statute requires?

A None at all.

Q Was there anything said about the hospitals getting reasonable costs under these regulations?

A Not at all.

Q Was Mr. McCann present when Davidoff said this to you?

A Yes, he was.

Q Was there anything said in connection with your conversation with regard to the ceilings on the routine-service cost reimbursements that you have just discussed?

A Yes. Mr. Davidoff stated that the state, in calculating the effect on state payment, had made a series of calculations, that they had calculated a ceiling based on 110 per cent of per-diem routine-service cost and per-case ancillary-service costs at 105 per cent, at 100 per cent, at 95 per cent and at 90 per cent.

Q And did he tell you why they made these calculations with ceilings at various levels?

A The -- I can't remember the exact words, but there was a very strong inference that the State Budget Director had -- had made available a certain sum of money for Medicaid purposes, and that the average level, that is, 100 per cent, this fit in with the Budget Director's expectations.

Q In other words, these calculations were being made backwards after they decided how much money there would be for the hospitals, is that the idea?

A Yes, sir, that was the very strong inference.

Q Now, does 86.14 provide for a ceiling on ancillary costs as well as reasonable costs?

A As well as routine --

Q As well as routine costs.

THE COURT: 86-which?

MR. IMBERMAN: 86.14B.

A Yes, sir, it does.

Q Had there ever been a ceiling on ancillary costs in the State of New York before?

A Not by the state, but by Blue Cross plans as part of a total ceiling.

Q And when Blue Cross included them as part of a total ceiling, then your limitation was 115 per cent of the group average, am I right?

A 115 per cent of the group per-diem average, not per case. That, to my knowledge, had never been done before.

Q Would you mind explaining for the record what you mean by a ceiling on a per-case basis as distinguished from a per-diem basis?

A Payment rates are established on a per-diem basis, and this is the customary unit of measure for inpatient services.

The ancillary ceiling that has been in use to establish 1976 payment rates is based on total ancillary costs divided by total discharges, in effect establishing a ceiling on the ancillary costs that may be permitted per case. That is for a total stay.

Q Under 86.14 what is the limitation, as far as the average is concerned? What is the maximum?

A The maximum is 110 per cent.

Q No, no, I'm talking about the new regulation. Isn't that 100 per cent?

A I'm sorry. I mean 100 per cent. My error.

Q Now, this is in contrast to 110 per cent under the prior -- under the present approved plan, am I right?

A That's correct, sir.

Q Now, would you please explain to the court what the effect is on hospital reimbursement of using a 100 per cent limitation as distinguished from 110 per cent?

A Well, the use of an average automatically means that half of the hospitals in my group, no matter how comparable the group is, no matter how efficient each individual hospital is within that group, that half the hospitals in that group will be penalized to some extent.

Q Regardless of whether their costs are reasonable or unreasonable?

A Correct.

Q And regardless of whether their costs result from effiencies or inefficiencies?

A Correct.

Q Did you ever discuss that matter with anybody in the State of New York?

A Only in these discussions we were having in Newburgh, and I was trying to convince the state people at that time that, first of all, I didn't believe that the regulation was particularly intelligent, that I understood that urgency of the situation, that the state had to come up with something, that they were under tremendous pressure to establish 1976 rates of payments, and that I -- that I was well aware that they didn't have the time to think through the effect.

I further pointed out during the course of these discussions that the effect was almost a random effect of helping some hospitals and hurting others without any particular regard to the merits of a situation. That, in effect, no matter what group of hospitals was involved, whether it was the medical center-type hospitals with all of the teaching programs that could be mustered or whether it was small community, semirural hospitals, that the effect would be exactly the same, the group would be divided into two categories, in effect, the haves and the have-nots was the expression I used.

THE COURT: The haves would be worse than the have-nots?

THE WITNESS: No, just the reverse, the have-nots would be hurt.

THE COURT: What I mean is that putting it my way a richer hospital, whose costs might be greater, would be above average and therefore get less.

THE WITNESS: You are right, your Honor, absolutely correct.

BY MR. IMBERMAN:

Q Now, could you explain to us briefly what sort of matters would affect a hospital's costs regardless of how efficient the hospital was?

A Well, no two hospitals are alike, no more than any two people are alike. They have a -- they have, first of all, a different community that they serve. The community could be older and they would have a greater proportion of Medicare patients, with the result, first of all, of a longer length of stay for the patients 65 and over and higher nursing costs for the patient at age 65, as contrasted, for example, with Nassau County, where the average age has been much lower and the percentage of medicare patients is generally much lower than would be found, let's say, in the Bronx.

Hospitals do not have an identical mix of services that they offer. They will offer varying beds available medical conditions, for surgical conditions, they will have varying capacities for pediatric cases, for obstetrical cases, for gynecological cases, for psychiatric cases. Each of these cases will have its own individual costs. That is, you can calculate a reasonable cost for a medical patient for a maternity patient, for a psychiatric patient. And even if two hospitals had identical costs for medicine, for surgery, for psychiatry, and down the line, simply because they had a difference in the mix, that is, the medical mix in hospital A might be 40 for the A, in hospital B 30 per cent, and so forth down the line, the result could be quite different.

Q As far as cost is concerned, per-diem cost?

A As far as average total service costs within the hospital.

Q Is it true, Mr. Ingram, that these various things that you have just mentioned produce different costs within a hospital regardless of how efficient the hospital itself may operate?

A Absolutely.

Q So that the use of this flat 100 per cent average will penalize any hospital which has a cost above the average regardless of its efficiency or how well it operates, isn't that so?

A That's correct, sir.

THE COURT: I take it even with the 10 per cent leeway that existed ror this some hospitals might have gotten penalized, too, if they were 115 per cent, for example?

THE WITNESS: Yes, your Honor.

THE COURT: So that one does have to recognize in the world of reality there has to be a limit somewhere?

THE WITNESS: No question about it, sir.

THE COURT: But you and plaintiffs in this case are suggesting that 110 per cent you believe came fairly close to actual costs and was reasonable, is that right?

THE WITNESS: In effect, sir, if I can go back, the 110 per cent protected the public from hospitals that were incurring aberrantly high costs.

THE COURT: Well, of course literally construed the statute would require the state even to pay aberrantly high costs, I suppose. If you follow through on the decisions that have been rendered so far about approximately actual costs, but I gather that both sides are prepared to agree that 110 per cent formula was an appropriate one, is that right?

MR. IMBERMAN: We believe so, your Honor.

THE WITNESS: Yes, sir.

BY MR. IMBERMAN:

Q Well, let me ask you this, Mr. Ingram: You are familiar with most hospital reimbursement plans throughout the country, are you not?

A Yes, I am.

Q Is there any plan that you know of that has a limitation of a flat 100 per cent of the average?

A No, sir.

Q Now, let me refer briefly to one other regulation to which your affidavit is addressed, and that is 86.21K, which was also adopted or at least promulgated by the state recently.

Would you mind explaining to the court how that operates and what effect 21K will have on hospital reimbursement from the viewpoint of reasonable costs?

A The state will match the increase in its trend factor with the increase in an individual hospital's per-diem costs. The state will allow the lower of the actual increase in cost or the increase in cost that would have been incurred at the rate of the trend factor. Thus, if a hospital's cost increased by 12 per cent in a given year and the trend factor was 10 per cent, the state will not recognize that additional 2 per cent. They will not recognize it in that year, nor in any subsequent year, unless the hospital produces actual costs less than the trend factor. That is, an increase in actual costs less than the trend factor.

It is, in effect, a cumulative penalty. I know that represents roughly corresponding to the method of reimbursement used by Blue Cross in 1948 through 1959, which was criticized severely by the then Superintendent of Insurance as rewarding some hospitals unjustly, and penalizing others unjustly.

Q The trend factor is really a sort of prediction by the Hospital Department of what -- the Department of Health -- as to what they expect inflation will be in a coming year, am I right?

A Correct, sir.

Q Well, what happens if they are wrong?

A Generally speaking, in so-called normal years the trend factor can be predicted with a great deal of accuracy. When you get a year like 1974 no economist can -- is able to predict what would happen in 1974. I think the track record of the economists was quite embarrassing to them, but they were willing to admit that there were external factors, primarily the energy crisis, that impinged on their ability to predict. When something of that magnitude --

THE COURT: Other people predicted that a long time before it happened, though.

THE WITNESS: Yes, sir, they did, but the fact that it happened when it did --

THE COURT: I don't mean to interrupt the logic of your presentation. I mean, the question of what is predictable in itself is an interesting proposition.

THE WITNESS: I don't know how many people predicted it, the war and its effect on the energy crisis.

BY MR. IMBERMAN:

Q Mr. Ingram, I'd like to address your attention to just one other regulation which is involved here, and that is regulation 86.26, which provides that the hospital's costs of salaries for interns and residents would not be recognized to the extent of 10 per cent of such costs on the basis that the elimination represents something called educational activities rather than patient services. Are you familiar with that regulation?

A Yes, sir, I am.

Q While you were at Blue Cross did Blue Cross make studies from time to time with respect to interns, their work week, their salaries, and the amount of time that they put in taking care of patients in the hospital?

A Yes, sir, particularly in connection with the Medicare regulations that, in effect, said the same as the state regulation does, that there must be a direct connection between educational activities and patient care. And we found in innumerable hospitals that residents and interns were getting didactic class= room instruction for some different hours per week. However, we found also that the average intern and resident was working a total of between 60 and 100 hours per week, and it was very difficult to determine whether the classroom instruction was being done with the 40-hour week for which he was theoretically being paid or whether it was done at the -- in the second 40 hours or whether it was done in the third 40 hours.

Q For which he was also being paid?

A Well, if you take the salaries of Doctors of Philosphy or Doctors of Science, other than Medical Doctors, and they go into commercial fields, I think you will find that their salaries are roughly comparable, perhaps higher than the salaries paid to residents, and that they work approximately a 40-hour week, whereas the resident is putting in up to 100 hours a week.

Q And you know -- do you recall now whether in any of these studies what percentage of or how many hours a week interns and residents might be --

A There was no average. It varied all over the lot, depending on the hospital, the program, the particular time that the resident was there, what service he was on at the time. It almost looked as though it was related to the type of teaching instruction he was getting from the chief of that service.

There were a whole host of factors. There was no pattern, in other words, that is what I'm trying to say.

Q But did you basically find that most of the interns and residents' time was spent taking care of people in the hospital?

A Oh, absolutely. We never eliminated a

single dollar as being devoted or dedicated to classroom instruction, not a dollar.

Q On the theory that the hospital was getting more than its money's worth from the --

A Absolutely.

Q -- interns and residents?

A Absolutely.

Q Over how many years are you familiar with such studies?

A From 1967 through 1975.

Q And to your knowledge, Blue Cross never eliminated a single dollar of interns and residents' salaries, is that right?

A That's correct.

Q Do you know of the existence of any studies which would justify this 10 per cent cut?

A No, sir, I do not.

Q Did you ever discuss this with any of the state officials, this 10 per cent cut in salaries of hospital interns and residents?

A Yes, sir. Again, in Newburgh, when we were having these discussions with state people, Mr. Davidoff stated that the Budget Director had said that he must get an additional $9 million from the Medicaid program, and that one of the methods of getting it would be to cut interns and residents' salaries by 10 per cent. I said that this would not produce $9 million; it was going to produce maybe $2 million overall. And Mr. Davidoff agreed with meand said that they would have to seek the additional money elsewhere.

Q Let me go back to 86.21K for just a minute. Does the limitation there take into account any new services or facilities that a hospital might put into effect?

A No, sir, it does not.

Q Well, would that serve to limit the hospital's ability to put into effect any new services and facilities?

A It would if it were introducing new services -- not necessarily new services, but new techniques of a so-called nonsubstantial nature. That is, any services that are introduced of a substantial nature -- and "substantial" being defined as having an annual budget of $100,000 a year or more -- by law in the State of New York have to go through the planning process and have to have the approval of the Commissioner of Health. Within Part 86 there are provisions for recognizing the cost of those approved services. However, if a hospital is introducing new types of instruments that are more costly, or a new x-ray machine that is more costly but does not come to a total cost of $100,000, there is no method for recognizing those additional costs.

Q Let me call your attention to one other matter, Mr. Ingram. A little while ago there was some colloquy between Judge Lasker and yourself as to whether or not the parties agreed that if the state went back to 110 per cent ceilings, whether that would be satisfactory.

You didn't mean that a 110 per cent ceiling on ancillary costs is what the plaintiff was approving, did you?

A No, sir, 110 per cent of per-diem routine-service costs.

MR. IMBERMAN: All right, you may examine.

CROSS EXAMINATION

BY MR. FINE:

Q I have just a few questions, Mr. Ingram.

I'm a little confused. You were referring to the studies made as to the percentage of time interns and residents devoted to what you referred to as, I think the word you used was, "didactic" matters.

A Classroom.

Q Classroom stuff?

A Yes, sir.

Q Apparently some time is devoted to that?

A Yes, sir.

Q You are not sure whether it is 10 per cent or 5 per cent or 12 per cent of the total houts spent by the intern in the hospital?

A As I said it, it varies considerably from hospital to hospital. There was no hospital that I knew of where it came even close to 10 per cent.

Q Well, you said that it varied greatly?

A It did, yes, sir.

Q Second, I wanted to ask you whether you were familiar with an action brought in the Supreme Court of the State of New York by Adelphi Hospital and a group of I think perhaps 150 more hospitals challenging the 1973 Medicaid rate. Are you familiar with that lawsuit?

A It was challenging the Blue Cross rates.

Q No, no, that was another lawsuit. That was the Presbyterian Hospital lawsuit. But there was -- you know that there was a lawsuit brought?

A Yes.

Q Challenging the 1973 rate?

A Yes, sir.

MR.FINE: And I should like Mr. Imberman to concede that this is the stipulation he signed and I signed settling, with respect to approximately 125 of the hospitals, that litigation.

May I show it to you, Mr. Imberman?

MR. IMBERMAN: Sure.

Yes, sir, I signed that stipulation.

Q Now, would you look at this and just let me ask you a question or two about it.

A Surely.

MR. FINE: May I say that what that stipulation does is to give effect to a decision by Justice Gellinoff in Supreme Court, New York County, which required the state to recompute the 1973 inpatient rates as well as emergency and clinic rates for Medicaid services.

Q Now, you will notice on the schedules annexed to it that what was done was to add the calculated increment arising from the recalculation of the 1973 rates to the 1975 rates, so that actually the 1975 Medicaid rates reflected not merely the pure 1975 rate, but an added factor, which in some cases amounted -- varied from $1 to maybe $10, resulting from a recalculation of the 1973 rates.

THE COURT: I'm getting confused. I thought the litigation challenged -- first I thought it challenged the '74 rates, then I thought it challenged the '73 rates, and now I hear the settlement approved the '75 rates.

MR. IMBERMAN: Your Honor, may I first object to the question on the ground that --

THE COURT: There isn't any question.

MR. IMBERMAN: -- the stipulation speaks for itself.

THE COURT: There isn't any question yet, but I'd think Mr. Ingram would probably like to understand what the document before us does purport to convey, with or without characterization by counsel, and I'm now asking questions since it is a technical matter.

MR. FINE: May I clarify it?

THE COURT: Yes, and let me take a look with you. Perhaps you can make reference to the document itself.

MR. FINE: May I hand it in as an

exhibit? I'm perfectly willing to submit it. Let me explain what it is.

THE COURT: We can make an exhibit hereafter.

MR. FINE: It is a stipulation signed by the attorneys, Mr. Imberman's law firm --

THE COURT: Yes, I know.

MR. FINE: -- and myself, settling a 1973 rate case.

THE COURT: That is a case relating to 1973 rates?

MR. FINE: That related to the 1973 Medicaid rates.

THE COURT: Right.

MR. FINE: The settlement was based upon a recalculation of about 125 hospitals.

THE COURT: They had been shown in Exhibit A here?

MR. FINE: That's right, sir, about 13 pages, listing all the hospitals. That schedule shows the additional increment to be added to the 1973 rate. Andthe way it was done in order to get it into the budget, since the 1973 budget had already long been passed, was to add on the increment to the 1975 rate, so that if --

THE COURT: So that, in effect, they get more in '75 than they would have otherwise gotten?

MR. FINE: That's right.

THE COURT: But it was actually compensated for what they didn't get in '73, is that right?

MR. FINE: What they didn't get in '73, which is due them from '73.

MR. IMBERMAN: Your Honor, there is no doubt the document speaks for itself, and I think substantially what Mr. Fine has said is so and it varies from hospital to hospital, but I might also say this business of adding on to a future rate, or deducting from a future rate where a hospital had been overpaid in prior years, is a practice of the Health Department. And in each case, if you would, starting -- if you wanted to know what the real components were of the 1975 rate you would have to do a lot of calculating. Because here there might be an add-on, somewhere else there'd be a subtraction.

THE COURT: Maybe so, but let's let Mr. Fine try and put before me whatever he's trying to put before me. You could always argue I should pay attention to it.

MR. FINE: I should like to submit to your Honor and Mr. Ingram that the 1975 rate did reflect adjustments made because of this 1973 rate settlement and may have ultimately reflected other adjustments made on appeals taken in connection with other hospitals in connection with other rates and which were adjusted in the same form by adding on to the 1975 projected rate.

MR. IMBERMAN: I object to the form. It might be subtracting also.

THE COURT: That may be true or not. I don't know if his expertise is going to add anything to this settlement.

BY MR. FINE:

Q Do you know anything about this settlement?

A I negotiated it on behalf of Blue Cross.

Q This is the same thing but it relates to the Medicaid rates?

A Yes.

MR. FINE: I should like to admit that into evidence.

MR. IMBERMAN: If your Honor please, I'm going to object on the ground it is irrelevant to this lawsuit.

THE COURT: I will receive it for what it is worth, as we say. I certainly understand the problems raised, but as I take it Mr. Fine is going to argue at a later time that '75 rates were higher than they otherwise would have been because of the impact of this suit and it may have some relevance to these little causes; you'll be able to argue that.

(New York State Defendant's Exhibit B was received in evidence.)

BY MR. FINE:

Q In your discussion you mentioned you had a discussion, I think in Newburgh and probably other times, with representatives of the Health Department.

Did they ever mention to you that they intended to supplement the regulations in Part 86 respecting the right of any hospital to appeal as a result of the amendment to the Part 86?

A Yes, sir. As a matter of fact, at a meeting prior to the meetings in Newburgh Dr. Kevin Cahill very specifically stated that there were approximately a dozen hospitals with extraordinary circumstances and that they had designed an appeal mechanism to, in effect, adjust the rates for these limited number of hospitals. At that open meeting I discussed with Dr. Cahill the difficulty of defining extraordinary circumstances,with a very strong inference to him that doing this for 12 hospitals could -- could have -- could very well open the door to many others, and he was rather adamant in stating that it was the intention of the state to limit this to 12 hospitals.

THE COURT: Who is Dr. Cahill?

THE WITNESS: Dr. Cahill is special assistant to -- for the Governor of the state for health care matters, sir.

BY MR. FINE:

Q None of these people mentioned to you the fact that actually on July 1, 1976 the commissioner promulgated a regulation known as "Revision in Certified Rates" to part 86.17 granting the right to hospitals to request relief from the ceiling provisions of Section 86.14? Do you know anything about that?

A These discussions were held prior to July 1st, sir, and I haven't had any discussion since.

THE COURT: Could you tell me what the regulation number is, the new one?

MR. IMBERMAN: Your Honor, I would also like to know whether this is a regulation that is supposed to be in effect yet? I don't think it is.

MR. FINE: No, it was.

THE COURT: I just want to know what we are talking about.

MR. FINE: Your Honor, on July 1, 1966 the Commissioner of Health -- may I make this statement so that it is a little preliminary? It is just a matter of getting this before the court.

On July 1, 1976 the Commissioner of Health filed with the Secretary of State of the State of New York a further amendment to Part 86.17 adding a subparagraph 7, granting further rights of appeal to any hospital affected by the new regulations. I should like to submit to your Honor -- well, I guess I can do it through my own witnesses, but this seems to be an appropriate time. I should like to submit the correspondence by which this Department of Health laid before its secretary, the majority leader of the Senate and the Speaker copies of the proposed regulations.

Any objection?

MR. IMBERMAN: I'd like to see what you are -- well, if your Honor please, I am objecting to these because I think they are entirely irrelevant.

I don't know what this third page is?

MR. FINE: This is the regulation.

MR. IMBERMAN: Because whether or not a particular hospital under these proposed regulations, which are not yet in effect as of July 20th, has the right to appeal or not I think is irrelevant in this lawsuit, where we are attacking the specific regulations which have been promulgated which we say are illegal.

THE COURT: I'll accept it.

(New York State Defendant's Exhibit B was received in evidence.)

BY MR. FINE:

Q Now, in your colloquy with his Honor you were discussing the fact that under the 110 per cent ceiling limitation certain hospitals would be, shall we say, prejudiced and some not so much prejudiced.

The same thing is true under the 100 per cent limitation, is it not? I mean, what actually did you say about it, the difference between the 110 per cent and the 100 per cent median average?

A What I said was that the 110 per cent ceiling protected the public in a reasonable manner from hospitals that had incurred apparently high costs, whereas the 100 per cent ceiling had almost a random basis and penalizes hospitals and without regard to whether the hospitals are operating efficiently or not efficiently.

Q Well, in one case you talk about protecting the public. In the other case you talk about penalizing the hospitals. But my argument, my question to you is this: doesn't the 100 per cent limitation as much or more effectively protect the public as the 110 per cent?

A Mr. Fine, you can establish a ceiling of 90 per cent, 80 per cent, 70 per cent --

THE COURT: I will take judicial notice of the fact that the 100 per cent protects the public in its role as the purveyor of money to the purveyor of services, yes.

MR. FINE: Well, I think, though, that Mr. --

THE COURT: The public is on all sides of this.

MR. IMBERMAN: Your Honor, I think Mr. Fine is really arguing with the witness now. I think everybody understands what the testimony has been.

MR. FINE: I just wanted to clarify it.

THE COURT: I rather explore the other side of it, Mr. Fine, which is what I raised before, and that is this:

Do you know, Mr. Ingram, to what extent hospitals were penalized under the 110 per cent formula in the sense that, aberrant or not, they didn't get back their reasonable costs?

THE WITNESS: A very small group of hospitals. I can't give you a percentage of my own knowledge, sir.

THE COURT: Have any studies been made?

THE WITNESS: I believe that the data could be produced for you,yes, sir.

BY MR. FINE:

Q Now, in addition to the operation of the ceiling in connection with the 1976 rates, there may have been other facts which you from your experience would know would affect the hospitals' rate, is that not true, apart from the application of the 100 per cent ceiling you had spoken about, like changes in use of the hospital, changes in -- there are other factors, are there not?

MR. IMBERMAN: If your Honor please, I object to the question because I think it is difficult to understand, and I'm not sure just what Mr. Fine means, so I'm not sure Mr. Ingram knows what he means.

THE COURT: If Mr. Ingram understands then he can answer it.

A There are many facts that go into hospital costs, the actual costs incurred, the salary levels they are paying, the number of people on the payroll, the utilization of the hospital, a whole host of factors, literally --

Q In other words, the hospital's utilization drops greatly, the cost would go up per patient per day?

THE COURT: It's unit cost.

Q It's unit cost would go up?

A Unless management made some effort to compensate for a drop which is customary by closing units, that kind of thing.

Q Well, I know, but don't these regulations, by putting these ceilings, in effect compel the hospital to operate as efficiently as it can to save money? Isn't that the whole thrust of these regulations?

THE COURT: I don't really think you can

ask Mr. Ingram what the thrust of your client's regulation is. You can ask your clients that.

If you mean the result, of course we are all inclined to be more efficient if we know that daddy's not going to give us as big an allowance. That really I think we have to come to grips with a larger question here, Mr. Fine, and that is whether that's what the statute, as construed by the courts, requires and authorizes. It's a really significant question.

MR. FINE: Are you referring to the payment of actual costs.

THE COURT: Yes.

MR. FINE: Well, the payment of actual costs, your Honor, would only be possible if you did it retroactively, and the whole thrust of the New York State system since 1970 has been to establish these prospective ceilings. We never are saying to any hospital, "We are going to pay you the actual costs."

I am the first to concede --

THE COURT: I know, but I'm still faced with a decision that says that is what the statute requires, although apparently it is --

MR.FINE: Mr. Ingram in his own affidavit, as I pointed out to you, has indicated the State of New York plans for prospective reimbursement has been approved by HEW.

I have no further questions at this time.

MR. IMBERMAN: I have no redirect, your Honor.

THE COURT: Thank you, Mr. Ingram.

(Witness excused.)

THE COURT: Can we start another witness now? Do you have any other witnesses?

S. DAVID POMRINSE, called as a witness by plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. IMBERMAN:

Q All right, Dr. Pomrinse, what is your occupation?

A I am the executive vice president of the Mt. Sinai Hospital.

Q And could you tell us briefly what your occupational experience has been since you received your medical degree?

THE COURT: Again I think Mr. Fine will probably waive that.

MR. FINE: I concede that.

THE COURT: It's in the affidavit.

Q All right, that's fine. Would you tell us then -- well, I assume that counsel is conceding that Dr. Pomrinse is an expert in the field of hospital administration, also reimbursement.

MR. FINE: I am perfectly willing to concede that.

MR. IMBERMAN: Thank you very much.

Q Please tell us briefly what your duties are as executive vice president of Mt. Sinai Hospital?

A I'm the chief executive officer of the hospital and I am responsible for its operations, planning, management, relations with the public, carrying out the directives of the board of trustees and abiding by all of the regulations promulgated by all the regulations.

THE COURT: This must be an important case if you could find time to come down here.

THE WITNESS: Yes, sir, it is very important.

Q Could you briefly describe for us the

kind of institution Mt. Sinai is?

A We are a 1200-bed medical center hospital affiliated with the Mt. Sinai School of Medicine. We act as a tertiary care center, which means a referral center for complicated and unusual cases that cannot be handled in typical community hospitals. We are a very large institution and have major teaching programs in a number of fields, as well as helping to support the clinical research done by the medical school.

Q And does Mt. Sinai also act as the hospital which services the East Harlem community?

A Yes, we service some 70,000 different human beings every year in our ambulatory care facilities, providing about a quarter of a million visits to those people.

THE COURT: 70,000 beds?

THE WITNESS: No, sir, this is ambulatory, walking patients, emergency room and clinics.

A Inpatient there are 31,000 discharges a year. So between the two we service about 100,000 people a year.

MR. FINE: Excuse me, sir. I am unable to hear Dr. Pomrinse. I didn't hear his last statement. Would the stenographer read it.

THE COURT: He was giving us statistics of the patients at the hospital.

MR. FINE: I just wanted to hear it.

THE COURT: 70,000 ambulatory, 31,000 inpatient discharges.

BY MR. IMBERMAN:

Q Try to project your voice, please.

Could you describe for us briefly the new Anner[illegible] facility which the hospital put into operatio[illegible] year?

A This was a building which was designed to house both our new school of medicine when it was planned and hospital facilities to support beds in other parts of the institution. The hospital portion is 45 per cent by square footage of a 33-story building, with almost a million square feet of space. It is a very recognizable tower on the Upper East Side.

THE COURT: It certainly is.

A Visible from quite a distance.

It makes possible the most sophisticated heart medicine and surgery, the center is probably the most sophisticated in the area. There are some 29 operating rooms, three floors of clinics, emergency room, and a very large x-ray department. Scattered throughout the building in the upper floors are clinical departments which house the chiefs of the various services and many of their offices and laboratories.

This program was put together in 1964 and 1965 with the help and support and approval of the New York State Department of Health, the Public Health Service of the Health, Education and Welfare Department, and indeed the State University of New York.

Contributions to its construction were received from those agencies. State University made a grant toward the medical school, HEW made a grant toward the construction of the building, and the Health Department of the State arranged with the housing finance agencies for a $41-1/2 million mortgage on the building.

Q Is it true that the Department of Health was intimately involved in all the planning and construction of this project from the beginning to the end?

A Every architectural drawing, every program description, every operating budget was individually reviewed, argued out and approved finally before it was put into execution by the department. There is a regulatory agreement that was signed by us a number of years ago which prohibits us from doing many different things without the prior approval of the state which goes beyond the usual controls under the planning law. We have abided by every specific of the planning law and have appropriate documents to demonstrate that.

Q Dr. Pomrinse, what was the Medicaid rate which Mt. Sinai Hospital received in 1975?

A $255.

Q And what is the --

THE COURT: That is per patient?

THE WITNESS: Excuse me. Inpatient-day, yes, sir. This is the average.

MR. IMBERMAN: I'm talking inpatient now.

THE COURT: Right.

BY MR. IMBERMAN:

Q And what is the Medicaid rate which the Department of Health announced Mt. Sinai Hospital would receive retroactively to January 1, 1976?

A $240, which includes $2 of retroactive funds relating to a prior year.

Q Now, Dr. Pomrinse, I am going to hand you a document which has on the first page the words

"Schedule of Rates" and is dated November 15, 1974, and I ask you if you can identify that document.

A Yes, sir, this is the submission -- that is the schedules attached with the submission by Mt. Sinai to the Commissioner of Health in support of our 1975 reimbursement rate, and the attachment shows the enormous detail which the State Department of Health reviewed and eventually approved at the $255, $259 maximum,expenditure rate.

Q Now, is it true that the pages on this document after the first three set forth the various types of services which Mr. Sinai Hospital provided during 1975 and for which it received the maximum rate on this documentof $259.35?

A Yes, sir, these were the new programs that were added as a result of the opening of the Annenberg building, which,added to our previous year's rate, ended up with $259 maximum.

MR. IMBERMAN: I offer this document in evidence, if your Honor please.

(Plaintiff's Exhibit 2 was marked for identification.)

xx THE COURT: Do you have any objection, Mr. Fine?

MR. FINE: No, your Honor.

(Plaintiffs' Exhibit 2 was received in evidence.)

BY MR. IMBERMAN:

Q Now, Dr. Pomrinse, you just testified that the state had reduced your Medicaid rate to $240 from $255, which it had been the prior year. Does this schedule or Exhibit 2 relate to the Medicaid rate which you received in 1975?

A Yes, sir.

Q Now, how do you --

THE COURT: How does it relate? When you use the word "relate," I understand it was submitted for the purpose --

Q Do the services which are shown in the documents which are attached to Exhibit 2 indicate the services which the hospitals would perform in connection with its treatment of Medicaid patients?

A Yes, sir.

Q And can you explain to us the difference between the $255 rate that you testified and the $259 which appears as the daily rate on the first page of Exhibit 2?

A We were on retrospective reimbursement last year because we were essentially a new facility. The changes that the Annenberg building brought about were so great that we were paid on a retrospective basis.

After the approval of these budgets with $259 as the maximum the state said that it would be reasonable to expect that the expenditures to support these various programs would not exxceed $259. We tried to be as careful and efficient as possible and were able to come in $4 a day under that and are being paid at that rate, after the calculations were made after the fact.

Q Now, in 1976 --

THE COURT: May I just ask one question?

Am I to understand that, in effect, the state agreed for '75 that it would pay you up to $259 per patient-day, but as it turned out your costs were only $255?

THE WITNESS: Correct. And that's what we collected.

Q Now, in 1976 is Mt. Sinai providing the same services which it provided in 1975, or more or less?

A More. There are in deed new services

that were approved that have been coming to stream or being put into effect this year.

Q Can you tell me whether in 1976, when you are providing more services than 1975 -- whether your costs of operating the hospital have gone up or have they gone down?

A Our costs have clearly gone up along with the general economy. Our best estimate at this time of the year -- remember, we are just over half way through the year and we do not know what the recent labor arbitration will cost --

THE COURT: Of course.

A -- but assuming it doesn't cost anything, our projection is that our costs this year will be $270 per patient-day, which would mean an increase from last year of just -- of under 6 per cent, which is less than the general cost of living inflation.

Q Now, would you briefly describe for the court the new programs that Mt. Sinai has put into effect in 1976, and as you describe each please tell me whether they were approved in advance by the New York State Department of Health?

A One very large, very expensive program is a 19-bed cancer chemotherapy unit in which patients who require combinations of extremely toxic medications are placed, four of them in plastic rooms with controlled air flow so they won't get infections, where these poins are administered to try to kill the cancer cells without killing the patient. This is a very expensive program which was fully approved by the state and budgets were approved and so on in earlier periods. We anticipate that that will cost approximately $1 million for operation.

We --

THE COURT: How much does every million dollars constitute in --

THE WITNESS: $2.50, roughly. Just a hair under 400,000 days.

Q What about the Annenberg project itself; has that created additional cost during the year 1976?

A The Annenberg project began to open in late 1974 and was largely implemented in '75. There is phasing up in terms of more activity. We are opening, for example, a second cardiac catheterization room, the first one having opened last year. The cost for the second one will be in this year's costs. That was also specifically approved in the Annenberg plans and the budgets were included.

We have acquired a computerized axial mammography machine,the scanners that you read about which came into effect in November of '75, so we have only a full year's use, this year. And that was also specifically approved by the State Commissioner of Health and requires support for personnel and so on to operate it.

Q You have a new coronary care unit that is coming into effect in 1976?

A Yes. On this heart center we have a six-bed coronary unit of the most sophisticated type. It is immediately adjacent to the cardiac operating rooms, the patients are supported by computer controlled sensors which tell the nurses and doctors what to do before it would be recognizable with stethoscopes and so on, and that will be open in 10 days. So that we will have five months of use of that this year, which will add to the total cost.

Q Are all the other new programs referred to in your affidavit? And I don't want to necessarily repeat any of the material there.

Let me ask you to consider for a moment the regulation promulgated by the state which eliminates from reimbursement 10 per cent of the costs of the salaries paid to interns and residents on the theory that this represents some sort of educational function. Are you familiar with the manner in which interns and residents work at the Mt. Sinai Hospital?

A Yes, sir.

Q About how many hours a week do they put in?

A We estimate that the average is approximately 80 hours a week per person.

Q And the range of salaries for interns and residents is what?

A From $15,400 for a new graduate, who was formerly called an intern -- the terminology has recently changed -- to $21,500 for a sixth-year resident, which is a man six years out of medical school, with increasing responsibilities each year.

Q And for what do you pay the interns and residents these salaries?

A The care of our patients.

Q And do you pay them any money to be educated?

A Certainly not. One doesn't pay a student. In the course of working one learns. I like to think I learned something every day or the day is wasted. Similarly, a house officer learns something as he does, as he works, as the years go on he learns more, he has more responsibility, he can do more, and he needs less supervision and the degree of supervision becomes less.

THE COURT: Well, even if there is an informal education what you are saying is that is outside of this scope of your payment.

THE COURT: Yes, sir.

BY MR. IMBERMAN:

Q Now, you have testified, Dr. Pomrinse, with regard to the lower rate which Mt. Sinai is going to receive this year from Medicaid -- what will be the effect of this lower Medicaid rate on the operation of the hospital, the medical center?

A Well, it would be disastrous. Leaving out any effect which the recent labor dispute may have had, there is simply no way that in the middle of the year, at the time these rates were -- are promulgated, that one could cut spending fast enough to recoup the $2 million in Medicaid funds alone, and, parenthetically, I have to say that the Blue Cross formula is tied to the Medicaid formula, so the total impact is not 2 million but more like 5-1/2 million.

There would be simply -- it's simply impossible at this stage of the year, or even in advance of the year to have made that large a percentage change and maintain all of the individually approved programs that the Commissioner of Health has agreed we should be doing in the public interest.

I have here the operating certificate of Mt. Sinai Hospital, which is issued by the State Department of Health. It is supposed to be displayed in a conspicuous place in the hospital, and the lists for the five specific programs as well as the bed count. This is our license to function, as I understand it, and nowhere does it say that we are not do all those things. This comes out regularly. You see this is dated this year.

THE COURT: Right.

A And it is our authority to carry out these programs.

THE COURT: Well, there is certainly no question you have the authority to do it.

Let me ask you the awful question that I asked Mr. Fine, too. What would happen, as you see it, if this court or the Court of Appeals should decide against you and this litigation goes on for a number of months uncertainly?

THE WITNESS: We are so convinced that

what we do is reasonable and our costs are reasonable, and we were willing to stand up to any examination of those costs, that I have advised our board of trustees to take their chances, if you like, during this, during the litigation. We are quite open to any examination by anybody as to what we do and whether or not we do it efficiently and reasonably.

I cannot conceive that when you abide by all of the regulations that are handed down by the State Commissioner of Health, by the federal government, the Joint Commission on the Accreditation of Hospitals, etc., etc., and that numbers of employees per service, costs per unit, and whatever, are in line, that the total is not reasonable.

THE COURT: I understand that point of view. There, of course, are, you know much better than I do, serious areas of concern in the mind of thoughtful people in the community these days as to how much of the total resources of the community can be put into medical care, and undoubtedly this case reflects the factors in that problem.

I take it that you would agree that no institution, Mt. Sinai or otherwise, would have the right unilaterally to decide it was going to double the size of its facilities and charge that to the state or federal government?

THE WITNESS: Absolutely.

THE COURT: Therefore, I just want to be sure that I understand you correctly that you believe that you have got the right to continue with the present level or the level that it is being operated because, for all practical purposes, that level of operation and its components have previously been approved by the state insofar as Medicare--Medicaid costs are concerned.

THE WITNESS: Yes, sir. And we have met the utilization level requirements and so on. We are not running things half empty and therefore pushing costs up abnormally.

I should point out, in line with your thoughts, if I can point out, which I agree with, that at meetings going back eight months with various state officials alternative ways of reducing total Medicaid spending were proposed, and rejected by them, ways which would not violate the Medicaid law, as I understand it.

BY MR. IMBERMAN:

Q Now, Dr. Pomrinse, you were present in the courtroom while Mr. Ingram was testifying, were you not?

A Yes, I was.

Q And you heard his testimony.

Do you recall the testimony he gave with respect to ceilings on ancillary costs?

A Yes.

Q And there was some discussion with the judge also with regard to that.

Could you please tell the court what you believe the effect on the hospital's being paid reasonable costs, providing services, results from the ancillary ceiling?

A Well, it clearly limits the diagnostic and therapeutic tools available to the medical staff if we say that you can only do so much because we have to stay within the ceilings. It impedes the applicationof modern medicine even in centers where people are referred for the most sophsticated modern medicine.

For example, one would think that the delivery of a baby was a pretty standard kind of episode in the hospital and that it ought to be comparable rrom hospital to hospital. But at Mt. Sinai we get an awful lot of sick mothers who have associated heart disease or blood disease or genetic problems, which take a great deal of study in order to ascertain the best method of treatment. Therefore, there is no question that we spend more on ancillaries, we provide more ancillary services than a community hospital where the mothers are almost invariably healthy, young women. This is bound to show up in extra costs.

There is just no way to do these services and not have them show up as costs.

Q So what you are saying is that if you have a 100 per cent average ancillary costs limitation that would prevent you from doing the kind of work that you described just now?

A Exactly.

Q . Now, would you, however, agree that the Blue Cross method, which has a 115 per cent ceiling for both routine and ancillary together, is a reasonable figure that you could live with?

A It's a reasonable level and it is one that we have lived with and can live with and still provide a very wide range of services.

Q One other area, Dr. Pomrinse. You are a member, are you not, of the New York State Medical

Advisory Commission?

A Yes. I was appointed in the fall of 1973.

Q And is it not the function of that commission to advise the Commissioner of Health with regard to various health-related matters, including reimbursement?

A This is a mandated committee under both federal and state laws, as I understand it, to the Department of Social Services, and is required to review all actions which would impact the Medicaid program. The commission was meeting quarterly during 1973 and 1974.

Q When was the last time the commission had a meeting?

A October, 1974.

Q Now, do I take it then that the committee has never had the opportunity to advise either the Department of Social Services or the Commissioner of Health with respect to the effect of the various regulations which are the subject matter of this litigation?

A That's correct. We have not met in a year and a half.

Q Were you present at that Newburgh meeting that

Mr. Ingram testified about?

A No, I was not.

MR. IMBERMAN: I have no further questions.

THE WITNESS: But I have heard, I was present at another meeting where similar statements were made. Senator Starky Lombardy is the chairman o f the Senate Health Committee of the State of New York Legislature and he has an advisory council that meets monthly, and at his June meeting, I think it was June 16th, Dr. Kevin Cahill, who was described appropriately as the special assistant for health to the Governor, and represents the Governor in health matters, and Mr. Donald Davidoff and Dr. Robert Whelan, the Commissioner of Health, were all present at which the same statement was made about the 110 per cent, 105 per cent and 100 per cent, 95 per cent of the ceilings. And that 100 per cent calculation produced the budgetary saving which the Budget Director had required.

Q And was there any discussion at that time by these august officials about the hospitals getting reasonable costs?

A I would say the discussion went the other way. We objected violently; pointed to the fact that 86.14 would lead to a homogenization, a mediocritization of the hospitals in this state, that it ignored all of the program considerations, it ignored health planning, was destructive to a whole other body of activity controlled by federal law in health planning, and desperately tried to get them to reconsider. We failed and that's why we are here.

MR. IMBERMAN: I have no further question.

CROSS EXAMINATION

BY MR. FINE:

Q Just a question or two. Can you tell me what Mt. Sinai Hospital's gross income is on an annual basis from all sources?

A Yes. I can give it to you precisely. Our budgeted income for this year is $125,453,000.

Q And how many Medicaid patients do you have during the calendar year?

A Eighteen per cent of our patients --

Q How many?

A -- of our inpatients are Medicaid.

Q Eighteen per cent?

A This figure includes both inpatient and outpatient income.

Q I didn't get the percentage.

A Right. The $125 million figure includes both inpatient and outpatient.

Q Yes, but I wanted to know what are the number of Medicaid patients, in and out, or patient-days, if you want to express it that way.

A Our patient-days are 18 per cent Medicaid. I am trying to find the multiplication.

Q Are Medicaid?

A Yes, sir.

Q Am I to understand you to say that in 1976 you expect to receive $2 million less than you received in 1975 from Medicaid?

A No, sir.

Q Will you clarify that statement?

A I did not say that.

Q I'm not sure about that.

A I said I would receive $2 million less than costs for Medicaid patients,

Q On a budget of $125 million?

A No, sir. The budget for Medicaid patients --

Q No, no, my question --

MR. IMBERMAN: I think the witness should be permitted to answer.

THE COURT: I think the doctor should answer the question, but I'd like to know the answer to both points.

First, let's see, your budget gives us a total of $125 million, and he asked you if it's 2 million below cost, and the total budget is 125 million, but could you tell us what the Medicaid budget is?

THE WITNESS: Let me divide the total into inpatient and outpatient and so on. The inpatient is $108 million, Medicaid is --

THE COURT: That's the total?

THE WITNESS: Total inpatient income. Projected at $10 million for this year. Medicaid is 18 per cent of that, which would come to about 19 or 20 million dollars. $2 million below that is an over 10 per cent figure below our per bed picture.

Q Did you give me only the inpatient or the outpatient.

A This is inpatient only.

Q And your outpatient figures?

A Outpatient is $12.282 million, of which Medicaid represents 40 per cent.

Q I'd like to get those figures clear again. When you spoke of the 1976, the $108 million, as your Medicaid, your total outpatient, I'm not --

THE COURT: Total outpatient?

MR. IMBERMAN: Total inpatient.

Q And what percentage of that is Medicaid?

A Eighteen per cent.

THE COURT: Nineteen million. He figures that the $2 million loss, if you want to call it that, as it clearly is, is arithmetically a little more than 10 per cent of 19 million.

MR. FINE: I have no further questions.

THE COURT: Thank you very much, doctor, it's been very interesting to hear you.

Mr. Fine, are you going to have any witnesses this afternoon.

MR. FINE: If your Honor will give me about five minutes to discuss the matter with my principals, I will be glad to let you know.

THE COURT: I'll wait in the robing room.

- -

WITNESS INDEX

Name	Direct	Cross	REdirect	Recross
James C. Ingram	21	53		
S. David Pomrinse	68	89		

EXHIBIT INDEX+

Plaintiff	Identification	In Evidence
1	8	
2	74	75
Defendant		
A thru C	10	
D	10	
B		60 63

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS 1/, as Secretary of The U.S. Department of Health, Education & Welfare,

Defendants.

76 Civ. 2027

AFFIDAVIT

STATE OF NEW YORK)
) ss.:
COUNTY OF NEW YORK)

SEYMOUR L. BUDOFF, being duly sworn, deposes and says:

1. I am the Associate Regional Commissioner for Medical Services of the Social and Rehabilitation Service of the Department of Health, Education and Welfare, Region II Office in New York.

2. I am making this affidavit in response to a request by this Court that the appropriate official from the Department of Health, Education and Welfare inform the Court of the status as Medicaid plan amendments of the three revisions to part 86 of New York State's regulations which are currently being challenged by plaintiffs herein.

3. William Toby, the Acting Regional Commissioner for the Region II office of the Social and Rehabilitation Service, is the HEW official with the delegated authority for approval of state plan amendments in the Medicaid program. See 45 C.F.R. Section 201.3(c). Mr. Toby is in Puerto Rico on Departmental business and will not return to the New York office until July 28, 1978. I am therefore submitting this affidavit in order to comply with this Court's request.

1/ The Secretary of HEW's surname is correctly spelled "Mathews"

4. I have served in my present capacity as Associate Regional Commissioner for Medical Services, of the Social and Rehabilitation Service New York office since April 19, 1976. In this capacity I serve as the principal expert, program manager and advisor for Medicaid program activities in the area covered by Region II which includes New York, New Jersey, Puerto Rico and the Virgin Islands. I am thoroughly familiar with the status of all of New York's Medicaid plan amendment submittals which are pending.

5. In relation to the amended version of section 86.14(b) which is challenged by plaintiffs, none of the plan amendment submittals received by HEW to date contains the version of section 86.14(b) as quoted by plaintiffs in Exhibit A to the affidavit of James Ingram. However, state plan amendment submittal 75 60 (Government's Exhibit E) purported to amend a portion of 86.14(b) and submittal 76-18 (Attached hereto as Exhibit A) purports to further amend the section. The version of 86-14(b) contained in submittal 76-18 differs from the version quoted in plaintiffs' papers in that the version submitted to HEW contains the expression "in excess of 100% over the weighted average" whereas the version quoted by plaintiffs substitutes the phrase "in excess of the weighted average." HEW has raised questions with the state regarding the version of 86.14(b) as contained in submittal 76-18 and, pursuant to 45 C.F.R. Section 201.3(b) has requested a meeting with the appropriate state officials to discuss this and other problems raised by all of pending plan amendments to Part 86. Although myself and other HEW officials have made numerous requests to meet with the State officials in order to obtain answers to the questions we have raised and have indicated that we are available to meet with them at any time convenient to them, the State has not yet responded in terms of suggesting a suitable meeting date. Until satisfactory clarification is received from the State regarding this and other issues raised by the proposed plan amendments, final action in the form of approval by HEW cannot be given.

6. In relation to the amended version of section 86.21(b) which is challenged by plaintiffs, that proposed change is contained, along with other proposed changes, in submittal 75-61 (Government's Exhibit C). The regional office of HEW has raised questions regarding the overall effect of various amendments to section 86.21 contained in the pending submittals and, as stated in pargraph 5, has requested a meeting with the State officials in an attempt to receive satisfactory clarification from them. Until satisfactory clarification is received by HEW, final approval of the proposed plan amendment cannot be given.

7. In relation to the amended version of section 86.26 which is challenged by plaintiffs, on July 20, 1976 the regional office of HEW received a proposed plan amendment designated as Submittal 76-41 (Attached hereto as Exhibit D) which contains that proposed amendment . Because of the recent nature of that submittal, HEW's review of that proposed change is in its very initial stages. This amendment, like all others submitted by the state, regarding reimbursement for inpatient hospital services, will be evaluated in relation to New York's total plan material for reimbursement for inpatient hospital services and a determination will be made whether the plan material as amended meets the regulatory requirements in 45 C.F.R. Section 250.30(a)(2)(ii) which apply to so-called "alternate methods of reimbursement" like New York's prospective rate-setting system.

8. State plans for reimbursement for inpatient hospital services , like New York's, which do not adopt the Medicare system of reimbursement based on actual costs (45 C.F.R. Section 250.30(a)(2)(i)), are referred to as "alternate methods of reibursement" and must meet criteria for approval which include:

> "(a) Incentives for efficiency and economy;
>
> (b) Reimbursement on a reasonable cost basis;
>
> (c) Reimbursement not to exceed that which would be produced through the application of the title XVIII standards and principles of reimbursement as modified under... this section;

((

(d) Assurance of adequate participation of hospitals and availability of hospitals services of high quality to title XIX recipients;

(e) Adequate documentation for evaluation of experience under the State's approved reimbursement plan." 45 C.F.R. Section 250.30(a)(2)(ii)."

The federal regulations also provide that state Medicaid plans which provide for payment of the reasonable cost of inpatient hospital services must be approved in advance of implementation by the Regional Commissioner of the Social and Rehabilitation Service. 45 C.F.R. Section 250.30(a)(2). None of the plan amendments, portions of which are challenged by plaintiffs herein, has received such approval.

Seymour L. Budoff
Seymour L. Budoff

Sworn to before me
this 22nd day of July, 1976

Notary Public

MARGARET K. HOLMES
NOTARY PUBLIC, State of New York
No. 31 20[illegible]60
Qualified in New York County
Commission Expires March 30, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

HOSPITAL ASSOCIATION OF NEW YORK STATE
INC., MISERICORDIA HOSPITAL MEDICAL
CENTER, BUFFALO GENERAL HOSPITAL, THE
GENESEE HOSPITAL, and THE MOUNT SINAI
HOSPITAL on behalf of themselves and
all other nonprofit hospitals which are
members of the HOSPITAL ASSOCIATION OF
NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to
hospital patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of
Social Services of the State of New
York, ROBERT P. WHALEN, as Commissioner
of Health of the State of New York, PETER
GOLDMARK, as Director of the Budget of
the State of New York, HUGH L. CAREY,
as Governor of the State of New York,
and DAVID MATTHEWS, as Secretary of
the U.S. Department of Health, Education
and Welfare,

Defendants.

---x

76 Civ. 2027

AFFIDAVIT

STATE OF NEW YORK)
SS.:
COUNTY OF Orange)

WILLIAM F. McCANN, being duly sworn, deposes and says:

At all times since June 1969, I have served as Assistant Commissioner and Director of the Division of Health Economics (now the Division of Health Care Cost Control) of the New York State Department of Health (the "Department"). In that capacity my duties have included development of methods for financing the delivery of health care throughout this state as well as the adequacy of reimbursement therefor by the State's Medicaid Program as well as by Article IX-C corporations.

CURRENT SITUATION: LEGISLATIVE AND ADMINISTRATIVE RESPONSES

1. Section 2807(3) of the Public Health Law contains a mandate that the Commissioner...certify... to the State Director of the Budget that the proposed rate schedules for payments for hospital and health related services are reasonably related to the costs of the efficient production of such service (effective Jan. 1, 1970).

2. The fiscal crises being experienced in both State and local governments could not go unnoticed by the Governor and the Legislature. Gross expenditures in New York State in the Medicaid program for the fiscal year ending March 31, 1977 were projected to be approximately $3,000,000,000. These projected expenditures represent an increase of 9.73 percent over Medicaid expenditures for the fiscal year ended March 31, 1976. An analysis of the projected expenditures shows that Medicaid expenditures for hospital inpatient services for the fiscal year ended March 31,1977 were projected to be in excess of $1,000,000,000. The projected expenditures for inpatient hospital services represent 34.6 percent of the projected Medicaid expenditures.

3. During the first few months of 1976 both legislative and administrative actions were taken in all areas requiring State expenditures in response to the limited resources available to carry on essential governmental programs. Such actions included the elimination of State jobs, a freeze on State employees salaries vacancy control, expenditure ceilings on Departments and Agencies, closing of State institutions and offices, reductions in aid percentages for certain local programs and reductions in capital construction programs. Certainly a State program with projected expenditures in excess of $3,000,000,000 warranted a comparable in-depth review.

4. With respect to the Medicaid program, separate legislative and administrative actions were taken. On the legislative side, Chapter 76 of the Laws of 1976 established limitations on both services and payments for certain aspects of the Medicaid program, excluding inpatient hospital service. With respect to inpatient hospital service, subdivision 2-a of Section 2807 of the Public Health Law directed the State Director of the Budget to take into consideration economic conditions within the State which affect the economic resources available to meet the cost of government-funded medical services. The review by the Director of the Budget of the rates certified by the Commissioner of Health, however, did not establish the need for action on the Budget Director's part in accordance with subdivision 2-a and he approved such rates as determined and certified without reduction or return to the Commissioner of Health for revision. (See Attachment 1)

5. With respect to administrative action, during the summer of 1975 and thereafter the Commissioner of Health was directed and urged to review the rate computation methodology in existence and assure that any inpatient rates certified to the Director of the Budget do not exceed levels of payment which are reasonably related to the costs of efficient production of service.

II

THE NEW YORK STATE HOSPITAL COST CONTROL PROGRAM

A. Background - Increasing Hospital Costs in New York State

6. For many years hospital costs have had a history of increasing at a pace significantly greater than the economy as a whole. The average cost per patient day in a general hospital throughout New York State rose by 146 percent from 1948 to 1960.

7. The increase in hospital costs accelerated in the early 1960s and these increases were rapidly reflected in increases in patient charges and rates. With such acceleration in costs it became a question of time before hospital services would be priced beyond the reach of significant numbers of New York State citizens.

8. Not unlike the current situation, the Governor and the Legislature, aware of the problems faced by all purchasers of health care services as well as by providers of service, initiated a program designed to restructure the system and assure the availability of services to all in need.

B. The Folsom Committee

9. As a first step, in 1964, Governor Nelson A. Rockefeller assembled a committee of distinguished citizens, entitled "The Governor's Committee on Hospital Costs", and chaired by Marion B. Folsom, a former Chief Executive of Eastman Kodak as well as Secretary of the United States Department of Health, Education and Welfare ("the Folsom Committee"). Appointing the Folsom Committee, the Governor remarked that "...The quality and extent of general hospital care available to citizens of New York State are unparalleled in history. Medical advances have saved countless lives and prevented untold cases of disability and prolonged suffering. However, the cost of hospital care continues to climb far beyond the price increases of food, clothing and shelter..."

10. In this light, the Folsom Committee was charged with making recommendations as to how hospitals might best provide high quality care at the lowest possible cost. And to improve the effectiveness of regulation of the State's hospital system, also requested of the Committee were suggestions as to the division of responsibility among State agencies with respect to hospital care.

11. In April of 1965, the Folsom Committee presented a summary of its final report. In response to the Committee's recommendations, the Legislature adopted several statutory changes during its 1965 session which became Article 28 of the Public Health Law.

12. The Folsom Committee's Report to the Governor, dated December 15, 1965, summed up such actions (at iv):

> "Under legislation sponsored by you and enacted by the legislature, important revisions were made in the public health, social welfare, and insurance laws of the State in a coordinated effort to restrain needless costs of hospital care and to improve the quality of health services.
>
> Steps have been taken to strengthen the control over needless construction and duplication of hospital facilities. Responsibility to develop and to administer the State's policies with respect to hospital and related services was assigned to a single appropriate agency, the State's Department of Health. The Commissioner of Health is empowered to conduct periodic inspection of facilities with respect to the fitness and adequacy of their premises, equipment, and personnel under rules and regulations adopted by the State Hospital Review and Planning Council. A uniform system of cost analysis and of reports was made mandatory. The Commissioner of Health is required to certify whether the rate schedules proposed for payment for hospital services by prepayment plans are reasonably related to the costs of providing such services. More equitable representation on the governing boards of non-profit prepayment plans is required. Such plans were empowered to offer more comprehensive benefits and to experiment with new forms of protectic The prospects for hospitals joining together in efforts to provide laboratory, laundry, purchasing, and other services have been increased."

C. The Advent of Medicaid and an Accelerated Rate of Increase in Hospital Costs

13. In 1966 Medicaid came upon the State scene. With this new program, the Department of Health adopted a prospective reimbursement method. The New York Medicaid program set its rate of reimbursement in the beginning of the year and this prospective rate was followed throughout the year. This prospective rate was designed to cover all costs hospitals should incur.

14. In July 1967, such use of prospectivity was abruptly halted: at that time the Federal government issued a regulation requiring that payments for inpatient services under Title XIX (governing State Medicaid programs*) be computed in accord with principles of reimbursement under Title XVIII (governing the Federal Medicare program). For all practical purposes, this ended New York State's prospective reimbursement and almost assured hospitals of full reimbursement of costs -- after they were incurred -- for about 82 percent of inpatient days (26.8 percent Medicaid, including municipal hospitals; 30 percent Blue Cross and 25 percent Medicare).

15. With Medicare, Medicaid and the Blue Cross plans reimbursing hospitals retrospectively on a full cost basis, the flood gates were opened· the annual costs of New York State's Medicaid program increased to over $400,000,000; and for 1969 hospital costs in the New York City area increased by 18.7%.

D. The Response of the Legislature

16. In 1969 the New York State legislators were faced again with the problems confronting the Governor at the time the Folsom Committee was appointed. The cost of the Medicaid program in 1968 at over $1,000,000.000 far exceeded the program projections of 1966.

17. The legislature enacted Chapter 957 of the New York State Laws of 1969 which became known as the cost control legislation of New York State. The legislative findings prompting the legislation again recognized the dangers posed by rapidly accelerating hospital costs and specifically questioned the wide unexplained variations in the cost of the same services rendered by hospitals in the same area.

---

* While the Medicaid program is administered by the State of New York, the Federal government contributes to the financing of Medicaid and thus exercises regulatory authority over the program.

18. Chapter 957 which revised Section 2807 of the Public Health Law directed the Commissioner of Health, in addition to the mandate cited in paragraph 1 above, to exclude:

1. costs for research,
2. those parts of the costs for educational salaries which the Commissioner shall determine to be not directly related to hospital services, and
3. allowances for costs which are not specifically identified.

The legislation went further and directed the Commissioner to take into consideration in certifying rates:

1. the elements of cost,
2. geographical differentials in the elements of cost considered,
3. economic factors in the area in which the hospital is located,
4. costs of hospitals of comparable size,
5. the rate of increase or decrease of the economy in the area in which the hospital is located, and
6. the need for incentives to improve services and institute economies,

The Commissioner must also take into consideration any economies and improvments in service to be anticipated from the operation of joint central services or the use of alternatives or substitutes for inpatient hospital service.

E. Administrative Actions by Department of Health

19. With the above legislative mandates a new cost-based prospective rate formula was developed by the Commissioner of Health and used in establishing rates effective January 1, 1970. In developing the formula the Commissioner took into consideration the facts that hospitals were previously reimbursed on a generally open-ended retrospective basis and that time would be required for

adjustment to a new system in which reimbursement would be limited. The prospective rate formula designed to influence hospital costs would have an impact on both Medicaid and Blue Cross rates which together exceed 50 percent of a hospital's inpatient utilization.

20. In no way could the first reimbursement formula under this new legislation be considered as a final product which would be the perfect solution to health care financing without constant revision to reflect changing health care patterns, economic trends, etc. The concept behind the prospective rate formula was and is to establish in advance the revenue parameters within which hospitals must operate and thus leave to the hospitals the decisions as to where economies and efficiencies could best be achieved in their individual institutions.

21. Certain basic elements must be present in a prospective rate formula in order for the formula to produce the desired result of influencing or controlling hospital costs. Basically:

1. the costs reported by hospitals must be challenged to eliminate on a broad base those costs not related to patient care and unjustified cost variances among hospitals of approximately the same size, providing approximately the same services and in the same geographic area;
2. the costs reported which are allowable for reimbursement must be trended forwarded to a prospective rate year by taking into consideration the increase or decrease in the economy in the area in which the hospital is located, and
3. the levels of payment reimbursed to the hospitals must be cost-attainable by the hospitals, while maintaining required levels of care.

New York State reimbursement formulas are designed to satisfy the above requirements.

22. Under the formula implemented on January 1, 1970, reported costs by hospitals were challenged by a peer group ceiling on routine inpatient costs. Hospitals were and currently are grouped by size, type (teaching vs. non-teaching), sponsor (proprietary, voluntary) and geographic area, and costs for certain activities are compared for reimbursement purposes. In the intial formula costs for hospitals in a group were limited to 110 percent of the weighted average cost per patient day of all hospitals in the group. As previously indicated, the Commissioner of Health took into consideration the need for time for hospitals to adjust to a new system and ceilings were not placed on ancillary services nor on ambulatory services.

23. With the exception of 1972 and 1973, during which the stringent federal Economic Stabilization Program was in effect, annual formula revisions have generally been made to strengthen the formula and better meet State objectives. These revisions continue to contain the basic elements indicated in paragraph 21 above.

24. Hospitals have generally failed to respond to the State's cost control efforts and the average annual rate of increase in per diem costs in New York State hospitals from 1970 through 1974 was 11.98 percent. In New York City, the average annual rate of increase during the same period was approximately 13.5 percent. Hospitals continue to incur expenses in excess of revenues.

III

RESPONSE TO ISSUES IN COMPLAINT

A. Reasonable Costs

25. Plaintiffs have taken the position that the administrative actions taken by the Department of Health violate the Federal requirement that hospital inpatient services for Title XIX patients be reimbursed on the basis of reasonable costs.

The position requires a definition of "reasonable costs". This is lacking in any of the papers submitted by plaintiffs.

26. The reimbursement formula developed by the State and properly filed in accordance with State law and regulation produces a level of payment for hospitals which, as Section 2807 requires, is reasonably related to the costs of efficient production of service. Thus, under State law and regulation the concept of "reasonable costs" is realized by eliminating from reported costs those elements of costs that cannot be justified by a hospital as being reasonably related to the costs of efficient production of service.

27. Federal regulations recently released with respect to reimbursement for Skilled Nursing and Intermediate Care Facility Services specifically discuss the definition of "reasonable cost". Basically, the Secretary re-defines a "reasonable cost" basis as a "reasonable cost-related" basis and indicates that there is no one method of determining reasonable cost. The Department of Health, Education and Welfare believes that a variety of cost-finding method could be used to determine reasonable cost, which methods would produce a range of amounts representing reasonable cost. A copy of the Federal regulations in which the reasonable cost concept is discussed is attached (Attachment 2)

B. Irreparable "Injury"

28. Plaintiffs contend that hospitals receiving in 1976 a rate lower than their 1975 rates will suffer immediate and irreparable "injury" in that it will seriously and permanently impair the ability of plaintiffs to render hospital and health services to the public. Plaintiffs cite the imposition of new ceilings as the primary contributor to the computation leading to a lower 1976 rate.

29. An analysis of 1976 rates for voluntary hospitals indicates that 83 are receiving a rate in 1976 that is lower than the 1975 rate. Of the 83 hospitals, 15 were not affected in any way by formula ceilings while 54 of the hospitals affected by ceiling penalties had disallowances which amounted to less than 2 percent of the hospital's inpatient costs. The remaining 14 hospitals had cost disallowances in excess of 2 percent. In other words, only 9.6 percent of voluntary hospitals in New York State which were affected by ceiling limitations had an over-all cost reduction impact greater than 2 percent of inpatient costs. In addition, a comparison of a rate in one year to a subsequent rate can only be an indication of cash flow since each year's rate generally contains adjustments relating to a prior year. For example, the 1975 rates contained a substantial amount included as a payment in 1975 for 1973 costs.

30. Of the four hospitals specifically named in this action neither Buffalo General Hospital nor Misericordia Hospital Medical Center were affected by cost ceilings under Section 86.14(b)

31. It is the State's opinion that in no instance did any of the hospitals in the action submit financial data supporting a position that it did not have sufficient resources to maintain the provision of health services at levels required under State law and regulation. The plaintiffs' position appears to be that if immediate relief is not granted the hospitals have no alternatives other than to immediately reduce the quantity or quality of services below acceptable levels. In no way has it been established that the plaintiffs have no other option.

C. Section 86.21(k)

32. Plaintiffs' papers cite 10 NYCRR Section 86.21(k) as being a material factor in the plaintiffs' asserted immediate and irreparable injury. This Section will have no cost or rate impact until 1978 when 1976 will be used as the base year for the determination of a prospective rate.

D. Section 86.14(b)

33. Plaintiffs contend that the imposition of new ceilings as contained in 10 NYCRR Section 86.14(b) deprives hospitals of reimbursement on a "reasonable cost" basis. Plaintiffs object to a new ceiling on ancillary service costs and the use of weighted average group per diem or discharge costs as a cost limitation.

34. The use of cost ceilings has long been established as an appropriate way of eliminating from reported costs in a cost-based rate computation process those costs which exceed established norms. The level of a cost ceiling related to hospitals' actual cost experience is directly related to the degree of comparability of the hospitals included in a group. In New York State, hospitals have been very carefully grouped as to size, area, type, characteristics, and other relevant factors. Therefore, a rigid ceiling is appropriate. Medicare, on the other hand, using a broad base for hospital groupings must use a ceiling at a level that, for all practical purposes, becomes ineffective.

35. As indicated previously, the reimbursement formula implemented on January 1, 1970 contained cost ceilings on routine inpatient services only, at 110 percent of a weighted group average cost. This was viewed only as an initial screening in a long range program to control hospital costs with such revisions as appropriat when reliable cost data became available from hospitals and in-dept analysis established the need for change as indicated by hospital behavior.

36. The use of a peer group average cost standard for determination of efficient operation and the allowance of a varianc from such standard had many limitations recognized by the Department at the time of implementation. It was deemed appropriate in 1976 to reduce the ceiling to the weighted average per diem cost for routine inpatient service to achieve reasonable levels of

payments by avoiding relating the cost standard to hospital cost patterns over the years which it has become apparent have not adequately responded to legislative and administrative intent.

37. A ceiling on ancillary service costs is not a new concept in reimbursement methodology. Blue Cross and Blue Shield of Greater New York has had such a ceiling in effect for the past five years by placing a per diem ceiling on the total costs of hospital operations. A recent study conducted by the Social Security Administration reported in June of this year on prospective reimbursement systems in the United States indicates certain success in influencing costs for non-physician dominated departments, basically routine inpatient services. The study also concludes that in physician-dominated departments the costs in hospitals under a prospective rate system continued to increase as rapidly as in hospitals reimbursed under open-ended retrospective system. The evaluators concluded that hospital administrators when faced with a need to control expenditures were reluctant to implement cuts in ancillary departments. The failure of the Department of Health to establish ancillary cost ceilings in prior years helped to contribute to these increases.

38. In determining an appropriate ancillary cost ceiling, the Department of Health selected a case method rather than a per diem method. With shorter lengths of stay the total ancillary service costs of a hospital are generally higher since basic services are provided to all patients. Put simply, the case method provides a comparison of the ancillary service costs for each inpatient entering a hospital. The average cost per patient of such services in hospitals that have been grouped together on the basis of size, type, characteristics, geographic area, sponsor, etc. is certainly an appropriate ceiling to be used in determining

a reasonable cost related level of payment.

39. The Department recognizes that individual hospitals within a group could certainly have costs in excess of average costs for a group that are completely justified. For example, costs of schools of nursing, costs of interns and residents and capital costs are eliminated from any ceiling computation under Section 86.14(b) because such costs are not comparable among institutions regardless of how carefully the hospital group for comparison purposes is selected. In addition, the Department is now processing an amendment to Section 86.17 which will provide for relief from ceiling provisions for facilities that can demonstrate that the costs in excess of the routine or ancillary ceilings are directly caused by a different patient mix, length of stay, etc. (See Attachment 3)

E. Section 86.26

40. In 1969 Section 2807(3) of the Public Health Law was amended. Among other things, this new provision required the Commissioner of Health to exclude from Medicaid and Blue Cross reimbursement "those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service***."

41. The above quoted provision requires the Commissioner to make a determination. Mindful, however, of the role of the State Hospital Review and Planning Council as to setting reimbursement standards not otherwise directly mandated by the Commissioner, this issue was placed before the Council. Unfortunately, the Council declined to adopt the proposed 10% disallowance..

42. Thereafter, the Commissioner, on the basis of his own existing authority, promulgated a rule excluding 10% of the 1974

cost of interns and residents salaries as being not directly related to hospital service. Neither the Director of the Budget, not the Commissioner of Social Services, both of whom urged the Commissioner to act, attempted to impose such a restriction on their own authority. In fact, only the Commissioner has been granted that responsibility by the Legislature.

43. The entire question of passing on medical education costs to patients has for too long been ignored. Beginning in 1970, the reimbursement process should have addressed this issue, instead of ignoring it until this time.

44. As for the decision to disallow 10%, there are specific studies which support such action. The National Labor Relations Board, in a recent decision (31 - RC - 2983 - Cedars-Sinai Medical Center) referred to a study by the Association of American Medical Colleges which concluded that about 80% of housestaff time is spent on direct patient care. In addition, a recent study on the same subject done for the Department of H.E.W. by the Committee of the Institute of Medicine of the National Academy of Sciences showed 10 percent of housestaff time is spent on learning.

45. Recognizing the difficulties of continuing a 10% deduction on an ongoing basis, the rule applies to 1974 reported costs and is applicable only to the 1976 reimbursement year. We are not aware of any hospital - housestaff arrangement where compensation is arrived at solely for patient care. The history of the industry does not reveal such a pattern.

F. State Plan

46. Plaintiffs contend that the State cannot implement new regulations without approval of the Secretary of Health, Education and Welfare. The Secretary has approved the methodology used by the State in its prospective reimbursement rate system at

the time of submittal in 1970. The revised regulations which have been submitted to the Secretary since his formal approval of the State plan effective prior to January 1, 1974 do not change the basic methodology.

WHEREFORE, it is respectfully submitted that the preliminary injunction sought herein should not be granted since the State has acted reasonably and the plaintiffs have not demonstrated immediate and irreparable injury.

William F. McCann
William F. McCann

Sworn to before me this
22d day of July, 1976

Donald A. MacHarg
Notary Public

DONALD A. MacHARG
Notary Public, State of New York
Residing in Albany County
Commission Expires March 30, 1977

7/26/76

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER and BUFFALO GENERAL HOSPITAL, on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York and DAVID MATHEWS as Secretary of the U.S. Dept. of Health, Education and Welfare,

Defendants.

---x

ANSWER TO AMENDED COMPLAINT

76 Civ. 2027
JUDGE LASKER

The defendants Toia, Whalen, Goldmark and Carey (hereafter referred to as the State defendants) answering the amended complaint herein by their attorney, LOUIS J. LEFKOWITZ, Attorney General of the State of New York, respectivelly:

1. Admit the allegations of paragraphs 16, 21, 22, 24, 25, 26, 27, 28, 35, 37, 58, 59 and 61 of the Amended Complaint.

2. Deny the allegations of paragraphs 18, 30, 34, 36, 42, 44, 45, 46, 47, 48, 49, 50, 51, 52, 62, 59 and 70 of the Amended Complaint.

3. Deny knowledge or information sufficient to form a belief as to the truth of the allegations of paragraphs 7, 8, 9, 10, 11 and 62 of the Amended Complaint.

4. Admit the allegations of paragraphs 12, 13, 14 and 15 of the Amended Complaint except that they deny the defendants named in said paragraphs are acting contrary to the Constitution and laws of the State of New York or of the United States.

5. Admit the allegations of paragraph 22 of the Amended Complaint except they deny that prior approval of the Secretary is required as alleged in said paragraph.

6. Admit the allegations of paragraph 28 except the last sentence thereof which they deny.

7. Deny the allegations of paragraph 31 except the first sentence thereof.

8. Admit the allegations of paragraph 32 except they deny the allegations of the last two sentences thereof.

9. Admit the allegations of paragraph 33 but deny that the recovery will threaten the financial viability of the hospitals and their ability to provide quality health care.

10. Admit the allegations of paragraph 38 but allege that Regulation 10 NYCRR 86.26 was promulgated as an emergency measure under the provision of New York's Executive Law § 110-a(2)

11. Admit the allegations of paragraph 40 but deny the members of the class will be reimbursed at less than reasonable costs.

12. Deny the allegations of paragraph 41 except the first sentence thereof which they admit.

13. Admit the allegations of paragraph 69 of the Amended Complaint but deny knowledge or information sufficient to form a belief as to the allegations of said paragraph that the cost of delivery of out-patient services to Medicaid patients is greater in 1976 than in 1975.

14. Admit the allegations of paragraph 64 except the last sentence thereof which they deny.

AS AND FOR A FIRST SEPARATE AND AFFIRMATIVE DEFENSE, THE STATE DEFENDANTS ALLEGE:

15. Public Law No. 94-182, § 111, 89 Stat. 1054, referred to in paragraph 59 of the Amended Complaint which requires the States to consent to suit in Federal Court by providers of in-patient hospital services and to waive the immunity from such suit under Amendment XI to the Constitution of the United States is unconstitutional and beyond the power of the Congress to enact. The State of New York executed its consent under protest and by reason of the fact that failure to execute the consent would have cost the State upwards of $40,000,000 in Federal Funds. The State executed the consent but expressly reserved the question of the propriety of the demand for this waiver. See letter dated March 31, 1976 from defendant Toia to Commissioner Toby of the Department of Health, Education and Welfare attached hereto as Exhibit "A".

The State defendants assert that this Court has no jurisdiction under said Public Law 94-182, nor under any other of the statutes cited in paragraphs 17 and 18 of the Amended Complaint.

Said Public Law No. 94-182, § 111 is violative of the XI Amendment to the Constitution and of the equal protection of the laws provided for in the XIV Amendment to said Constitution.

AS A SECOND, SEPARATE AND AFFIRMATIVE DEFENSE, THE STATE DEFENDANTS ALLEGE:

16. This action against the State defendants is an action against them as officials of the State of New York. The

State has not by constitutional provision or statutory enactment--consented to suit in the Federal Courts nor to a waiver of its sovereign immunity from suit in Federal Court. This Court is without jurisdiction.

AS A THIRD, SEPARATE DEFENSE,
THE STATE DEFENDANTS ALLEGE:

17. By Chapter 76 of the Laws of New York of 1976, the Medicaid rate of payments to hospitals for out-patient services was set at 100% of the level of payment made in 1975. Chapter 76, § 11(2)[illegible]). Said Chapter 76 is constitutional and not violative of the Social Security Act of Federal Regulations issued thereunder. Count II of the Amended Complaint and the prayer for injunctive relief set forth in the Amended Complaint would necessarily restrain and enjoin the operation of this statute by the State defendants. Such restraint may only be ordered by a district court of three judges. 28 U.S.C. § 2281, 2284.

The State defendants respectfully request that a three-judge district court be convened to adjudicate the issue.

WHEREFORE, the said State defendants ask judgment dismissing the Amended Complaint.

Dated: New York, New York
July 26, 1976.

Yours, etc.,

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for State Defendants
Office & P. O. Address
Two World Trade Center
New York, New York 10047
Tel. (212) 488-3391
By:

JESSE J. FINE
Assistant Attorney General

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12243

PHILIP L. TOIA
EXECUTIVE DEPUTY
COMMISSIONER

March 31, 1976

Dear Bill:

Enclosed is the State Plan amendment demanded by you under penalty of fiscal sanctions in your Action Transmittal SRS-AT-76-14(MSA) dated January 28, 1976. This submission is designed to facially comply with the requirements of Section 111, P.L. 94-182, December 31, 1975.

Please be advised, however, that there are serious questions being raised by this and other states as to the constitutionality of the requirements imposed by this statute. Accordingly, this submission should not be interpreted as an acquiescence by us of the legal appropriateness of this demand. Indeed, we expect such questions to be resolved in an appropriate legal forum in the near future.

Sincerely,

Phil

Philip L. Toia

Honorable William Toby
Acting Regional Commissioner
Social & Rehabilitation Service
Region II
Department of HEW
Federal Building
26 Federal Plaza
New York, New York 10007

EXHIBIT A-P.1

☆U.S. (RNMENT PRINTING OFFICE — 1974-[illegible]-213

RTMENT OF HEALTH, EDUCATION, AND WELFARE
AL AND REHABILITATION SERVICE
ngton, D. C. 20201

Submit 6 Copies

[illegible] 1976

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION NY

TRANSMITTAL NUMBER 76-8

STATE New York

PROGRAM IDENTIFICATION XIX

OF PLAN MATERIAL (CHECK ONE)
NEW STATE PLAN
AMENDMENT TO BE CONSIDERED AS NEW PLAN
AMENDMENT

PROPOSED EFFECTIVE DATE January 1, 1976

LETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

RAL REGULATION CITATION
P.L. 94-182, Section 111

ER OF THE PLAN SECTION OR ATTACHMENT
Revised page 24a-Title XIX Plan
as required by SRS-AT-76-14

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Page 24a

ECT OF AMENDMENT
State Consent to Suit

RNOR'S REVIEW (CHECK ONE)
GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

ATURE OF STATE AGENCY OFFICIAL

D Stephen Berger

LE Commissioner

March 30, 1976

RN TO:
NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED 1 APR 1976

DATE APPROVED [illegible] MAY 1976

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

William Toby

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME: William Toby

TITLE: Acting Regional Commissioner

REMARKS

[illegible]

Revision: SRS-AT-76-14(MSA) - 24a -
January 28, 1976

State NEW YORK

Citation
45 CFR
250.70
F.R. 40-36

4.27 Disclosure of Information on Providers of Health Care Services and Contractors.

The State agency has established procedures for disclosure of information on providers of services, contractors, carriers, intermediaries and State agencies. These procedures meet all requirements of 45 CFR 250.70.

P.L. 94-182
Sec. 111

4.28 State Consent to Suit

The State hereby consents to allow suit in Federal court by or on behalf of providers of inpatient hospital services with respect to payment of reasonable costs of such services, furnished for any period after June 30, 1975, pursuant to section 1902(a)(13)(D) of the Act. The State waives any immunity from such a suit under the eleventh amendment to the Constitution or otherwise.

EXHIBIT A
p 3

Presidency, New [illegible]

[illegible]

by [illegible]

STATE OF NEW YORK
COUNTY OF NEW YORK } ss.:

...., being duly sworn, depose and say that he is .... in the office of the Attorney General of the State of New York, the Attorney for .... herein. On the .... day of ...., 19 he served the annexed upon the following named persons:

[illegible]

Attorney in the within entitled .... by depositing a true and correct copy thereof, properly enclosed in a post-paid wrapper, in a post-office box regularly maintained by the Government of the United States at TWO WORLD TRADE CENTER NEW YORK, N.Y. 10047 directed to said Attorney at the address within the State designated by .... for that purpose.

Sworn to before me this
.... day of ...., 19

....

Assistant Attorney General of
the State of New York

....

Index No. 76 Civ. 2027 (LASKER)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

HOSPITAL ASSOCIATION OF NYS
INC., et al.,

Plaintiffs,

- against -

PHILIP L. TOIA, et al.,

Defendants.

ANSWER TO AMENDED
COMPLAINT

LOUIS J. LEFKOWITZ,
Attorney General

Attorney for Defendants Toia,
Shalen, Goldmark & Carey
Office And Post Office Address
Capitol, Albany, N.Y. 12224
New York Office
TWO WORLD TRADE CENTER, NEW YORK, N.Y. 10047
Tel.

Personal service of a copy of
within ....
is admitted this .... day of
....19

---

e take notice that the within is a true
duly entered here n in the office of
of
N.Y., , 19
Yours, etc.
LOUIS J. LEFKOWITZ,
Attorney General,
ey For
ce And Post Office Address
pitol, Albany, N.Y. 12224
New York Office
DE CENTER, NEW YORK, N.Y. 10047
, Esq.
for

---

take notice that the within
ented for settlement and signature
e Hon.
Judges of the within named Court, at
gh of
York, on the day of
19 , at M.
, 19
Yours, etc.
LOUIS J. LEFKOWITZ,
Attorney General,
For
And Post Office Address
tol, Albany, N.Y. 12224
New York Office
CENTER, NEW YORK, N.Y. 10047
, Esq.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----------------------------------x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., et al., :
Plaintiffs, :
-against- :
PHILIP L. TOIA, et al., :
Defendants. :

-----------------------------------x

76 Civ. 2027

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

James C. Ingram, being duly sworn, deposes and says:

1. I submit this affidavit in further support of plaintiffs' motion for a preliminary injunction herein and in response to the affidavit of Assistant Health Commissioner William F. McCann.

2. Defendants claim that 10 NYCRR §§86.14(b), 86.21(K) and 86.26 do not change the methodology in the approved State Plan and therefore can be implemented without the prior approval of the Secretary (McCann affidavit ¶46). The Medicaid Act and regulations and the affidavit of Seymour Budoff submitted on behalf of defendant Mathews demonstrate the opposite.

> "The federal regulations also provide that state Medicaid plans which provide for payment of the reasonable cost of inpatient hospital services must be approved in advance of implementation by the Regional Commissioner of the Social and Rehabilitation Service. 45 C.F.R. Section 250.30(a)(2). None of the plan amendments, portions of which are challenged by plaintiffs herein, has received such approval." (Budoff affidavit ¶8).

3. Assistant Health Commissioner McCann was in the Courtroom at the July 20, 1976 hearing in this matter when I testified to the conversation which I had with him and Donald Davidoff, Associate Director, New York State

Health Department, Division of Health Care Cost Control, on June 22, 1976 at the Holiday Inn in Newburgh. In McCann's presence, Mr. Davidoff stated that the purpose of the challenged regulations was to reduce State Medicaid payments to hospitals. Further, he strongly implied that the calculation of Medicaid rates was being controlled by the amount of money which had been made available by the defendant Budget Director and not by any desire to reimburse hospitals their reasonable costs. (transcript pp. ¶36A-39). It is significant that nothing in McCann's affidavit contradicts my testimony.

4. Defendants attempt to justify their illegal conduct on the grounds that in-patient hospital costs in New York rose between 1970 and 1974. (McCann affidavit ¶2). Apart from the fact that it is impossible to verify defendants' figures since their source is not given, they contain no information comparing the increase in New York hospital costs in these years either with increases in the general economy or increases in the hospital costs of other states. Moreover, they do not indicate how much of this increase is attributable to inflation, over which hospitals have no control. A study conducted by Professor William L. Dowling for the Department of Health, Education and Welfare entitled "Evaluation of Blue Cross and Medicaid Prospective Reimbursement Systems in Downstate New York" (Draft - June 1976) found, that on the basis of average per diem costs, the increase in non-profit hospital costs between 1970 and 1974 was less for downstate New York hospitals than

for hospitals in Chicago, Cleveland and Philadelphia. Dowling concluded that, after eliminating the effects of inflation and out-patient workloads, the New York hospitals' inpatient costs rose 7.4% from 1970-1974 as compared to 22.0% for the other metropolitan area hospitals. Dowling Report I-22-23. This represents an average increase of approximately 1.9% per year in the costs of the downstate New York hospitals which in my opinion is primarily attributable to new programs and facilities approved by the Commissioner of Health as well as the introduction of new scientific techniques. The average annual increase for the other metropolitan area hospitals in the Dowling study was almost three times as great - namely 5.5% per year. The report further found that under prospective reimbursement

> "both adjusted cost per day and adjusted cost per case increase rates slowed substantially under PR [Prospective Reimbursement]. *Adjusted cost per day increases in DNY [Downstate New York] non-profit hospitals dropped to one-quarter of their pre-PR rate (a rate equal to one-third of the 1970-1974 control hospital [Chicago, Cleveland, Philadelphia] rate). Adjusted cost per case increases in DNY non-profit hospitals dropped to one-third of their pre-PR rate (a rate equal to two-thirds of the 1970-1974 control hospital rate).* Findings of for-profit, teaching, and non-teaching hospitals are similar."
> Dowling Report I-24 (Emphasis in original)

A copy of this report is annexed hereto as Exhibit A.

5. The fact that hospital costs may increase from year to year does not mean that these increases are unreasonable. Defendants themselves have acknowledged that reasonable hospital costs have increased between 1975 and 1976 by calculating projection factors for costs ("trend factors") which show an inflationary increase in the New York hospital economy for this period of time. For the voluntary and public hospitals the calculation sheets of the Department of Health indicate that these trend factors are as follows:

HOSPITAL GROUP	1975-1976 TREND FACTOR
Teaching, New York City	8.65
Teaching, New York Suburban	7.72
Teaching, Upstate	7.65
Voluntary, Non-Teaching NYC	8.41
Voluntary, Non-Teaching, NY Suburban 75000 Patient Days & Under	7.82
Voluntary, Non-Teaching, NY Suburban over 75000 Patient Days	8.25
Voluntary, Non-Teaching, Upstate SMSA 50000 Patient Days and under	7.49
Voluntary, Non-Teaching, Upstate SMSA over 50000 Patient Days	7.60
Voluntary, Non-Teaching, Upstate Rural 30000 Patient Days	7.63
Voluntary, Non-Teaching, Upstate Rural over 30000 Patient Days	7.14
New York City, Municipals	6.72
Psychiatric	8.34

In light of these figures, it is impossible to understand how reducing 1976 hospital reimbursement rates below 1975 levels can result in reasonable cost reimbursement.

6. Moreover, despite their repeated claims that the ceilings on cost imposed by the challenged regulations comply with the requirement of reasonable cost reimbursement, defendants have never attempted to show that a single item of cost of a single hospital has been incurred in an unreasonable manner.

7. Defendants reliance (McCann aff. ¶27) on HEW's reimbursement regulations for skilled nursing and intermediate care facility services and their claim that the Secretary has defined "reasonable cost" to mean "reasonable

cost-related" is misleading. The Medicaid Act requires that skilled nursing and intermediate care facility services be reimbursed on a "reasonable cost-related basis" and not on a "reasonable cost" basis as is required for in-patient hospital services. The preamble to these regulations makes this distinction apparent.

> "The statute requires payment for long-term facility services provided under the plan 'on a reasonable cost-related basis,' rather than simply requiring payment of 'reasonable costs,' as in section 1902(a)(13)(D) (payment for inpatient hospital services) and section 1861(v) in title XVIII (Medicare)."
> 41 F.R. 27302, col. 3 (July 1, 1976)
> Attachment 2 to McCann affidavit.

The preamble goes on to make clear that payment under the "reasonable cost-related" standard can be lower than under the "reasonable cost" standard. However, even in the case of this lower payment level, a state's financial resources cannot determine the level of reimbursement.

> "[A] State would not satisfy the requirement of section 1902(a)(13)(E) if it paid, or gave assurance to pay, the amount determined under this section to the extent that State funds are available, or to the extent that State appropriations permit. To allow a State to limit its obligation under the statute by such a provision, as some comments suggested, would permit a State to defeat a major part of Congress' purpose in enacting...[section 1902(a)(13)(E)].
> 41 F.R. 27303, Col. 1 (July 1, 1976) - Attachment 2 to McCann affidavit.

8. It is true that the Secretary recognized that there can be a variety of cost-finding methods which meet the "reasonable cost" standard. However a cost-finding

method cannot impose arbitrary limits.

> Some States are now considering imposing arbitrary limits on the increase in hospital costs which will be recognized in the reimbursement rate. Such simple limitations on cost do not meet the requirements for reimbursement of reasonable cost specified in §250.30(a)(2)(ii).
>
> (Emphasis supplied)

FIELD STAFF Information and Instruction Series: FY-76-62 State Plan Changes, January 2, 1976, issued by Department of Health, Education and Welfare, Social and Rehabilitation Service, p.9

A copy of this memorandum is annexed hereto as Exhibit B.

9. Defendants claim that only 9.6 percent of the New York voluntary hospitals had cost reductions greater than 2 percent as a result of the ceilings in the challenged regulations. (McCann affidavit ¶29). This is a completely misleading number. McCann's affidavit makes it clear that this 9.6 percent was calculated only on the basis of hospitals whose 1976 rates were lower than their 1975 rates. In addition to those hospitals whose 1976 rates were reduced below 1975 levels, there are a great many hospitals with higher 1976 rates who were also denied reasonable cost reimbursement as a result of 10 NYCRR §86.14(b) and 86.26. In total, I believe that at least 160 of the voluntary hospitals were affected by 10 NYCRR §86.14(b) and 103 were affected by 10 NYCRR §86.26.

10. Defendants attempt to justify the use of an average ceiling on routine and ancillary service costs on the ground that their hospital groupings take the differences in hospital operation into account. For purposes of ceiling calculations, defendants group hospitals solely on the basis of the following criteria; type (teaching or non-teaching hospitals); geographic area for non-teaching hospitals; size; and sponsor (voluntary, public or proprietary). Defendants' own regulations show that these are the only

criteria used. 10 NYCRR §86.13 - Approved State Plan Attachment 4.19-A. - Plaintiffs' Exhibit 1. Defendants grouping obviously does include a great many factors, such as patient mix, age, and plant design, which will create natural differences in hospital cost.

11. Defendants suggest that elimination of costs of schools of nursing, interns and residents, and capital costs from ceiling computations as well as their plan to adopt an appeal mechanism for 10 NYCRR §86.14(b) overcomes the argument that the average ceilings do not allow for the natural differences between efficiently run hospitals. (McCann affidavit ¶39). As I have explained, there are many factors other than those enumerated, which produce differences in hospitals. More than 61% of the non-profit hospital in the State for whom rates have been calculated have been adversely affected by 10 NYCRR §86.14(b). An argument that the regulations authorize appeals is hardly an answer to our claim since a regulation whose application requires more than 61% of these hospitals to file an appeal can only be arbitrary in its operation.

12. In any event, even if hospital groupings reflected many more factors than they do, the 100% ceilings would still not be an accurate measure of reasonable cost. This is a result of the fact that if a mathematical average is used as a ceiling there must be some hospitals which exceed the average while others will be below it.

13. Defendants claim that the Medicare ceilings are ineffective (McCann affidavit ¶34), but they have not offered any evidence in support of this conclusion. These ceilings serve the function they were intended for - they protect the public against aberrantly high costs.

14. Defendants claim that hospital cost data showed the need for the use of the average ceilings. (McCann affidavit ¶35, 36). However they have not made any such cost data available. Moreover, this conclusion is contradicted by the findings of the Dowling Report referred to in ¶4 above which also concludes that

> "Blue Cross and Medicaid...prospective rates have not covered the portion of inpatient costs attributable to their patients. Blue Cross and Medicaid prospective rates consistently understated their own definitions of cost as well as the average cost for all patients. Dowling Report I-39 (Emphasis in original).

15. Defendants attempt to justify the average ancillary service cost ceiling on the ground that Blue Cross and Blue Shield of Greater New York has an ancillary service cost ceiling (McCann affidavit ¶37). However, the Blue Cross ceiling is equal to 115% of the group average of routine and ancillary service costs, and is calculated on a per patient day basis rather than a per discharge basis. A per discharge ceiling can only be valid if the service costs being compared are the same. For example, if the delivery costs of 1 hospital were compared with another this could be done on a per discharge basis. But if delivery costs are combined with surgical costs, radiological costs and physical therapy costs a per discharge comparison just won't work.

16. Defendants have not offered anything to show that the costs of interns and residents are not solely attributable to the services they perform. The fact that these doctors may be learning at the same time as they treat patients does not mean their services are not related to

hospital care. Moreover, since interns and residents work an average of 60 to 100 hours a week, they are obviously providing full time hospital service.

/S/ JAMES C. INGRAM
JAMES C. INGRAM

Sworn to before me
this 28th day of July, 1976.

/S/ Susan Rosenfeld
Notary Public

SUSAN ROSENFELD
Notary Public, State of New York
No. 31 4656009
Qualified in New York County
Commission Expires March 30 1978

skex

HOSPITAL ASSOCIATION OF NEW YORK
STATE, et al.,

v. 70 Civ. 2027

PHILLIP L. TOIA, as Commissioner of
Social Services of the State of New
York, et al.

New York, New York
July 28, 1976 - 11 a.m.

- - -

THE COURT: As I have explained to counsel in the robing room, there are two points I would like to cover this morning.

One is to hear from Commissioner McCann, who is not present because he is driving down from Albany, to fill in or to answer certain questions that arise in my mind as a result of this very interesting and stimulating affidavit.

I know that there are questions to be asked of the witness.

The other thing is to clear up confusion which arises out of different or what appear to be different points of view on the part of the federal defendants and the state defendants as to precisely what the degree of approval is required by the federal government before the state government is free to implement its new regulations.

It seems to me at least that material contained in Mr. Fine's memorandum of law in opposition to application for the preliminary injunction is inconsistent with material contained in the affidavit of Seymour Budoff, the Associate Regional Commissioner for Medical Services of the Social and Rehabilitation Services of the Department of HEW, Region 2, in New York.

If counsel are able to reconcile those differenc by their discussion, fine. If not, I would like to hear testimony, if necessary or at the very least, argument.

Mr. Fine, perhaps it would be most effective if you would explain to us what your views are as to the interrelationships between state action and federal approval here and then let Mr. O'Connor and Mr. Imberman have their say.

MR. FINE: The implication in Mr. Budoff's affidavit that the state has been negligent in seeking HEW approval, I requested the Department of Health, Education and Welfare to bring to court the original and copies of certain correspondence, one, a letter from the State Department of Social Services dated July 14, 1976; they have the original in court, but I am sure Mr. Imberman and Mr. O'Conno would not object if I submit these copies.

THE COURT: Of course not.

MR. FINE: And a copy of the incoming letter fro Mr. Budoff to the Department of Social Services dated July 10th and I ask that they be marked in evidence.

THE COURT: All right. Bring them up, please.

I take it there is no objection.

MR. O'CONNOR: We have no objection, your Hono

(State Exhibit B was received in evidence.)

MR. FINE: If you look at the index for the minute I want to discuss that with you, your Honor.

The minutes -- by the way, the exhibits are right here on the table now.

I should also like to introduce and I thought I had --

THE COURT: What confusion is there about exhibit numbers? Let's get it straightened out if there is a problem.

MR. FINE: There seems to be listed as exhibit -- there is no confusion, except that I thought that I put into evidence -- if you don't mind, I will approach the bench --

THE COURT: Please do. It is hard to hear in here.

MR. FINE: -- a letter or two letters, really, written by Donald McCord, counsel for the defendant, whom I expect will be here with Mr. McCann, transmitting to the Speaker of the House and the Majority Leader of the Senate, regulation number 8626, which --

THE COURT: Those were attached to your brief.

MR. FINE: Right. I think it would be appropria to introduce them into evidence. I have shown them to Mr. Imberman.

MR. IMBERMAN: Are you putting them in again?

MR. FINE: I am not. I thought I put them in the last time, but apparently I was mistaken.

There are copies annexed to my memorandum of law; they are the same things.

THE COURT: Of the last exhibit there -- I am confused, I thought that you said Exhibit B, included a letter from the state to the federal government dated July 14th and I see that and something coming back from HEW.

MR. FINE: There is a letter dated July 10th.

THE COURT: I don't see a July 10th. Let me give you this back.

Wait a minute. It is June 10th.

I am marking as Exhibit B the letter of June from Mr. Budoff to Mr. Raymond Diehl, Acting Deputy Commissioner, Division of Medical Assistance, New York Department --

MR. FINE: The last exhibit marked at the previous hearing was Exhibit B. May I suggest you mark this exhibit C.

THE COURT: No. I am remarking them because of the chronological order.

Then I am remarking as Exhibit C the letter of July 14, 1976, from the State Department of Social Services to Mr. Budoff with substantial attachments.

Now, the others can be dealt with.

MR. IMBERMAN: What is Exhibit A now?

THE COURT: Whatever was admitted the last time.

MR. IMBERMAN: Whatever was put in on page 10 originally.

MR. FINE That is a stipulation. That was admitted, I think, into evidence.

THE COURT: All right.

MR. FINE: Your Honor, I should now like to offer into evidence the news release referred to in the affidavit in support of the application for the injunction by Mr. Hartline. This is the complete news release and I should like to offer that in evidence.

(State Exhibits B, C and D were received in evidence.)

MR. IMBERMAN: My problem with the news release is that I would like to be able to cross examine the gentleman who put out the news release.

THE COURT: Didn't you say it is attached to one of the affidavits already? I don't think it needs to be put

jblt

in. On a motion for preliminary injunction, I don't want to get hung up on the technicalitites. Whatever is in the evidence is at least in evidence to that state.

MR. FINE: It is an affidavit of Mr. Hartline, one of the officials, and he refers to this news release.

MR. IMBERMAN: Your Honor, counsel stipulated that he wasn't going to controvert.

MR. FINE: I am not. I just say this is a news release.

THE COURT: I don't think it is necessary to put it in evidence.

Now, I would like to get to the purpose for whic the hearing was called, namely, to have evidence if necessar or argument in any event, on the extent to which approval is required, when it is required, to permit the state legally to commence the implementation of its regulations.

Mr. Fine, I do call on you first to explain what the state's position is in that regard. I am not sure that I thoroughly understand from your memorandum.

MR. FINE: Our position is very simple:

The statute under which we are operating is the Social Security Act and it requires that a state plan be approved by the Department of Health, Education and Welfare. The regulation, however, which the plaintiffs rely on, refer

jblt

to --

THE COURT: Which one are you talking about?

MR. FINE: Regulation 45CFR250.30(A)(2),which says in effect that a regulation with respect to hospital reimbursement rates shall, prior to implementation, be approved by HEW, and that it is not to become effective until approved by the Secretary.

The language of the statute itself requires the approval by the Secretary. It says nothing about, prior to the implementation of a new set of regulations becoming effective, such approval shall be required.

Sections 205B --

THE COURT: Isn't the word "approval" reasonably to be construed as meaning approval in advance? I mean certainly you wouldn't want to get it approved ten years from now.

MR. FINE: Ordinarily, your Honor, but I must tell you that there are other provisions of the Code of Federal Regulations which cast grave doubt on that and the grave doubt is cast upon it by this fact. That Regulation 45CFR205.5(B) provids for federal financial participation as to additional expenditures resulting from an amended provision of the state plan as of the first day of the calendar quarter in which an approvable amendment is admitted or on

jblt

the date on which an amended provision becomes effective in the state, whichever is later.

Now, we submit to your Honor that the regulations in issue here are approvable. I am not urging that they will be approved or disapproved. I am simply saying that they are approvable in the sense that they are regulations dealing with the precise issue of how a state may, under a previous plan which the HEW approved of, providing for prospective reimbursement, that these regulations are approvable.

As approvable, as distinguished from approved, we submit to you regulation 250.30(A)(2) is not consistent with the requirement that a regulation be approved prior to implementation. In other words, there is a dichotomy between the regulations.

Further, I should like to point out to you that ordinarily HEW is required to give 90 days, to act within 90 days after the submission of a state plan, unless there is a agreement in writing by which the state agrees that that period of time may be extended and because of negotiations o controversies respecting the plan.

Now, in the present case, most of the amendments, the amendments in question, were most ly submitted within less than 90 days from today. In other words, they are comparatively recent.

Now, HEW, the thrust of our argument as I said in the brief and I would just dislike reading from it, but it seems to me that it sums it up so concisely that I have no recourse.

On page 6 of my memorandum --

THE COURT: I read it and I think I understand it but I just wanted to be sure I did.

MR. FINE: What I am dealing with is, shall I say, a minute point of law, a matter of exegesis of some words that are contained in the regulations and the statute.

I would like to tell your Honor something else I think is interesting:

HEW for years has let the state operate without withdrawing financial funds without approval of amendments to the regulations.

Let me cite to your Honor specific cases.

The last HEW approval of any amendment of a state lpan was on -- you know, HEW marks each transmittal with a designation number showing the year and the date of the transmittal. And the last approval of any amendment to the state plan was designated 74-2, and was approved on December 31, 1974.

Since then some eight amendments, starting back in 1975 -- as a matter of fact, in 1974 -- have been submitted to HEW; the state has acted on them and HEW has never approved them.

THE COURT: Or disapproved.

MR. FINE: Or disapproved.

Never acted on them at all.

THE COURT: In other words, in a sense they are pending .

MR. FINE: They are pending. To be specific and since regional counsel for HEW is present here and the U.S. Attorney, I will read off the submittals on which there have been no action. I will read them in reverse chronological order.

7/12/76, the middle number, 76-41. Well, I can scarcely ask them to act on that. That involves one of these regulations.

THE COURT: One involved in this case?

MR. FINE: Yes, your Honor.

Submittal number 76-20, submitted on June 3, '76, which I don't believe involves these three regulations.

Submittals number 76-18, which was submitted on April 29, 1976 and which involves Regulation 76-14B.

Submittal number 75-62, which was submitted on December 17, 1975, which does not involve any of the regulations in this case.

Submission number 75-61, which was submitted on December 17, '75, involves regulation 82-21K.

Submission number 75-60, submitted on December 17, '75.

Submission 75-33, submitted on July 17, '75.

Submission number 75-13, submitted on July 17, '75.

And submittal number 74-13 and 74-2, submitted on April 19, 1974.

My point is that HEW has never been as insistent on approval and yet has let the state act under these regulations and I submit that that is consistent with our position that regulations dealing with reimbursement -- after all the construction of the question is shall the federal government pay the state money, reimburse it money.

HEW has never cut back on New York State's reimbursement formula, despite the fact that these regulation have not been approved.

HEW has never insisted on, shall I say, nor has the state for that matter, in fairness to HEW, ever complained.

Now, a lot of what I say is primarily because I want to rebut any inference in your Honor's mind that the state has not been as diligent as the HEW bureaucracy in thi area and I use the bureaucracy in no disparaging terms, because we understand that these are complex matters which have to be analyzed and thought through.

Reverting to my statutory argument, I think that what we have here is a set of regulations, the regulations we are now talking about, the three regulations, adopted basically in the face of the state's financial emergency, rushed down to Washington, to HEW's regional office in the last few months of the year when the impact of the emergency crisis came home and on which HEW and the state have not, sh we say, been able to resolve all the differences, but as the exhibit I introduced shows, at least the State Department of Social Services, whom I might mention is the state agency which deals directly with HEW -- under the 42 USC, each stat has to designate some agency to deal with HEW and in this case it is the Department of Social Services and the Department of Health has to act through the Department of Social Services and that is the thrust of the argument -- which is if we have not gotten the approval of the HEW, it is because they have 90 days in which to act and in any event, we can act on an approvable regulation as distinguished from requiring implementation of approval.

THE COURT: Thank you, Mr. Fine.

In the first instance --

MR. IMBERMAN: I think Mr. O'Connor ought to carry the brunt of this.

MR. O'CONNOR: Thank you, your Honor.

THE COURT: I am not suggesting that you should necessarily disagree with Mr. Fine. I haven't any idea what your position is but I would like it clarified.

MR. O'CONNOR: Well, your Honor, for the federal defendant, we do disagree with Mr. Fine with regard to the legal requirements and the issue that has been raised with regard to prior approval as opposed to approvable and as I understand Mr. Fine's argument, he says two things -- one, he is saying that the regulation relied upon, one specific requirement that there be advance approval, I understand him from the brief and the argument to be saying that that is inconsistent with the statute.

I also understand him to be saying --

THE COURT: The statute under the two regulations which are in conflict with each other.

MR. O'CONNOR: Yes, he also makes that argument, that they are inconsistent.

In this case, the statute and the regulations do gel by the terms and I don't think that it will be difficult to resolve the question by recourse directly to the language

jblt

involved.

The statute that the regulation is promulgated under and the statute that is in controversy in the present case is Section 42 United States Code, Section 1319(6)(A) an with the following subsections -- (A)(13D).

It is a short section and I wouldlike to read it to you in drawing your Honor's attention to the particular language involved.

1319(6)(A) states:

"A state plan for medical assistance must provide"-- and then the subsection (D) that I referred to has a particular requirement. It says this:

"The state plan must provide for payment of the reasonable cost of in-patient hospital services provided under the plan which have been developed by the state and reviewed and approved by the Secretary and (after notice of approval by the Secretary, included in the plan.)"

THE COURT: It is all part of D?

MR. O'CONNOR: Yes, your Honor.

So the first point, your Honor, is the statute itself by its specific language speaks about prior approval. It speaks about it in the following language that I have already emphasized -- after notice of approval by the Secretary, is when it shall be --

jblt

THE COURT: Let me ask, I don't know -- in the government's view, is there any difference between the need for approval of a plan and the need for approval of an amendment to a plan?

MR. O'CONNOR: Well, your Honor, I think in this particular case we are talking only about amendments.

THE COURT: We are but I wasn't able to gather whether (13)(D) refers to amendments specifically as well as the plan.

MR. O'CONNOR: It does not specifically state amendments. It talks about the plan shall apply and it is our position that this does not apply to amendments to the plan.

With respect to that statute, the Secretary has promulgated the regulation that is relied upon here, 45 CFR 250.30(a)(2), and this regulation tracks almost exactly the language of the statute. It states:

"State Plan Requirements:

"A state plan for medical assistance under Title 19 of the Social Security Act must, 2, provide for payment of the reasonable cost of in-patient hospital services as determined in accordance with methods and standards which shall be developed by the state and approved in advance of implementation by the Regional Commissioner."

So, the first point I make is there is no inconsistency between the regulation relied upon and the statute. The regulation tracks exactly the wording and inter of the statute.

That brings us to the second point. Is there some inconsistence between the regulations? Mr. Fine argues that there is. However, the regulation that he relies upon is 45 CFR Section 205.5 (b), and this provides -- federal financial participation. It starts:

"Except where otherwise provided, federal financial participation is available. As of the first day of the calendar quarter in which an approvable amendment is submitt or the date on which the amendment provision becomes effective in the state, whichever is later."

The point is, the section that Mr. Fine is relyi on starts with the words "except where otherwise provided," so the regulations come down to this type of scheme.

In general, the statute, the regulation relied upon by Mr. Fine applies for most types of amendments. The state can, if it submits an approvable amendment, it can be effective as of the first day of the calendar quarter in which it is submitted. That is the general rule.

However, the regulation itself says except where otherwise provided.

Now, both the statute and the regulations carve out a certain exception to that general rule and that certai exception is applicable where you are talking about reasonable costs for reimbursement of in-patient hospital services so that is a key point.

THE COURT: What in effect you are saying is tha regulation 250.30(a)(2) does otherwise provide?

MR. O'CONNOR: Exactly, your Honor.

And the key to the carving out is now we are talking about not the general financial participation, but now we are talking about reasonable cost of in-patient hospital services, which are the greatest percentage, so what the Congress did was carve out a certain section with regard to in-patient and it said, okay, generally we will let you put in an approvable plan, but when you are in the area of in-patient cost, you have to have the plan approved first, before you can implement it.

So, it is the Secretary's position that there is no inconsistency there between the regulations relied upon in the statute or in the regulations themselves and the way this developed is because of the difference between a genera rule and an exception that applies to in-patient hospital services.

THE COURT: When you say it is the "Secretary's "

jblt

position, I know who you represent, Mr. O'Connor, and I don't mean to question you, I don't mean to question the authority of your own statement in any way, but I would like to know just precisely what you mean by that.

Have you been in discussion for example with the General Counsel's office of the Department or is this argument your own argument; has it been a matter that the Department has had to consider before and rule on? What do you mean by saying it is the Secretary's position?

MR. O'CONNOR: Well, your Honor, as far as the background goes, the authority background, this has been discussed with Regional Counsel for the Department of Health, Education and Welfare. These cases have come up before. I am not saying precisely on the point, but the position as developed between myself and the Regional Counsel is that there is no inconsistence in these regulations.

These set out the legal requirements. That is the reason that the Secretary promulgates them, because he is following the statute and he wants to have prior approval with regard to the in-patient costs. The reason he wants that is because that is what Congress recommended.

THE COURT: What do you have to say to answer th point made by Mr. Fine that whatever the regulations say, the practice has been to allow the amendments to be jbIt

implemented even though they have not in fact been approved.

MR. O'CONNOR: I would like to do that and befor

that I would like to make two brief remarks:

Mr. Fine has pointed out there is a 90 day requirement. There is no question of that. However, Mr. Fine also pointed out that with regard to the regulations that we are talking about, most of them have been submitted within 90 days, so there is no inconsistence between saying that the Secretary has not acted yet. They have been submitted recently.

The other point is this:

With regard to, and Budoff will be able to testi to this, approval that goes beyond the 90 day period, it is the policy of the Department of Health, Education and Welfare, to notify the state that it is considering these, that there are certain questions and to ask for an extension or to inform them that they are going beyond the 90 days.

As Mr. Fine also has stated, the state has never objected to any of the time requirements that we are talking about here and very few of the things that he mentioned -- he mentioned that I have nine submittals that he articulated very few of those, I think I only have two of them, which ar involved in the current controversy.

I do not know what is involved in the other submittals.

THE COURT: That may or may not be relevant but that is not the point. What he is saying is as a matter of general practice, regardless of what the regulations say, they have not been literally implemented; that the government -- this is something I suppose we should hear from somebody about and I don't mean to say that is it will control but I would like to know what the practice is or has been.

MR. O'CONNOR: Well, I just wanted to bring to your Honor's attention before Mr. Budoff testifies, what Mr. Fine said about the eight submittals, we don't know exactly what they involve, we don't know if they fall in the category of approvable, as opposed to the in-patient; he did not specify that.

THE COURT: I know. We do not know a lot of things and lawyers cannot answer that for us and that is why we have the witness here.

MR. O'CONNOR: We can call Mr. Budoff.

THE COURT: Before you do that, Mr. Imberman?

MR. IMBERMAN: I have just one word to add, your Honor. There is nothing I can say to improve upon Mr. O'Connor's argument on the important part of the aspect and that is the alleged conflict between the statute and the regulations.

He has answered it precisely.

I have no knowledge of what has been going on between the Department of Health of the State of New York and HEW and the practices that they have indulged in with regard to plan approvals, what they relate to in-patient reasonable cost or some other technical things that do not matter very much.

The only point I want to make, your Honor, is it hardly seems fair to me that if these two governments indulge in whatever practices they do, as between themselves, that can hardly affect the right of the plaintiffs here to ask your Honor to enforce the law.

THE COURT: Well, I would agree to this extent -- that it cannot be binding. I would not say it is irrelevant to whether I should grant the injunction against the state or not, at least if I come down to the question of whether the injunction should be granted, because approval has not been secured but certainly you are right; there are three parties here, not just two, and the interests of all three are necessary.

MR. IMBERMAN: I think perhaps it would be helpful to be hearing from the witness.

MR. FINE: May I speak for a moment on something

Mr. O'Connor said?

THE COURT: Yes.

MR. FINE: In discussing 45 CFR 205.5(b), he laid great emphasis on the opening words of the paragraph, "except where otherwise provided."

I submit that that modifies federal financial participation is available. It does not disqualify or minimize or negate my argument that if an approvable plan is submitted, that the state may act on that basis. The words "except where otherwise provided, financial participation is available." The "federal financial participation is available" is what is modified by "except where otherwise provided" and I do not think that language reasonably states the present implementation --

THE COURT: I am glad to have you add that argument but I won't attempt to construe the regulation on the bench here. It is going to be difficult enough to do it somewhere else.

Do you want to call Mr. Budoff then, Mr. O'Conno

In effect, Mr. Budoff is being called as a Court witness, if it makes any difference to anyone else. It doesn't make any difference to me who calls him.

jblt

SEYMOUR BUDOFF, called as a witness on behalf of the Court, having first been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. O'CONNOR:

Q Mr. Budoff, would you tell us your position, please?

A I am the Associate Regional Commissioner, Medical Services Administration, Social Rehabilitation Services, HEW Region 2.

Q As part of your position, Mr. Budoff, do you hav any connection with amendments to state plans submitted by New York State under what is called the Medicaid Federal Plan?

A Yes.

The regional office, Region 2, has the responsibility of reviewing plan materials on Medicaid submitted by the state.

Q Are you personally involved in this process?

A Yes, I am.

Q Would you please explain to the Court briefly the process of approval.

A Well, the process of approval begins when the state submits either a new plan material or a plan amendment

That material has to be evaluated by my staff and myself.

It is evaluated to insure that, number one, it is consistent with federal statute, federal regulation and in order to make that determination, the material is evaluated and hopefully a decision is reached.

Q Now, when you say evaluated, why can't you tell just from looking at the piece of paper that is submitted whether it is consistent or inconsistent? What evaluations are there?

A The evaluation is to determine that what is being submitted, which very often is a complicated piece of material, often involving principles that have to be looked at and determinations made to insure that what is being submitted once approved would be consistent with requirements that exist in federal statute regulations.

Q Are you familiar with submittals entitled 76-18, 76-41 and 75-61?

Are you familiar with those submittals?

THE COURT: Those are the submittals of the three regulations involved in this case?

MR. O'CONNOR: Yes, your Honor.

A Yes, I am.

Q Could you explain briefly again, with regard to these specific plan amendments, what type of approval process -- where are you in your approval process with regar to these three submittals?

A These three submittals in the main, relate to amendments to the methodology the state will use in order to determine reasonable cost reimbursement to institutions -- hospitals in particular.

Our review of those amendments requires that we, number one, evaluate what is being submitted as the amen ment, try to make determinations as to whether or not the application of that methodology will indeed and in fact lead to the reimbursement of reasonable costs to institutions.

In order to do that, we have first reviewed the material. A number of questions were raised in our minds as to how this or these new regulations would be applied by the state and we are at the process now of having shared with th state our questions with regard to the specifics of the materials submitted and are seeking to hear from the state as to their representations of what they propose to do would in fact lead to reasonable reimbursement and in that way satisfy our concerns with regard to the material submitted.

Q Are you familiar with a requirement in the regulations that the Department of Health, Education and Welfare will approve, act within 90 days of the submittal?

A Yes, there is such a regulation.

Q One of these three regulations, of the submittal that I mentioned earlier, as far as you can recall, have any of them been submitted to the Department of Health, Educatio and Welfare before 90 days from now?

THE COURT: More than 90 days.

A 90 days ago? Yes.

Q Now, with regard to that submittal, what is your practice in light of the fact that you have gone over the 90 days?

A Well, when we are approaching the 90-day time limit, we make it a practice to notify the state that we are approaching the 90-day limitation and that we will be continuing beyond the 90 days to review this.

Q And how do you notify them? By telephone or meeting --

A By mail.

Q Has the state responded, has the state objected to any of these letters?

A Not to my knowledge.

Q Have they answered in any way? Have you received any communication from them so far as you know, sin the time you told them you would go beyond the 90 days?

A Specifically relating to the 90-day period?

Q No, any communication regarding the submittals.

A Well, yes, we did receive a communication from them on July 14th, I believe.

Q And as far as you can recall, is there any mention in that letter of an objection to the 90-day requirement?

A No, there was no such objection.

MR. O'CONNOR: I would like to have this marked as Government's Exhibit E for identification.

(Federal Exhibit E was marked for identification.)

Q Mr. Budoff, I now show you State's Exhibit B for identification and State's Exhibit C for identification and Government's Exhibit E for identification and ask if you recognize these.

MR. IMBERMAN: Excuse me, are not B and C marked in evidence?

THE COURT: Yes.

I think he is talking about the covering letter.

A Just the covering letter or the attachments as well?

Q Just the covering letter.

A Yes, I recognize it.

Q Could you tell us what it is, briefly? What they are?

A Exhibit B is a letter that I wrote to the single state agency indicating to them that we had finished our review of the material that they had submitted in one of their submissions -- I don't have the exact number -- and we sent this covering letter along with the matrix of the areas that we wanted further clarification from the state about, requesting that they review the material and we would like to meet with them to discuss our questions around the material that had been submitted.

Q Could you explain briefly, what do you mean by a matrix?

A Well, it was a compilation of the results of our review, where we took each section individually and indicate where we had questions around that section, what those questions were, requesting that they prepare themselves to be able to satisfy us with regard to the questions we had raised on each section of that submittal.

The next exhibit is marked C, and this is the response that the state sent us to the letter of June 10th.

The following exhibit is marked E, and that is our response to the state's letter of July 14th.

MR. O'CONNOR: At this time I would like to offer in evidence the Government's Exhibit E for identification.

THE COURT: Show it to counsel.

MR. O'CONNOR: I offer this in evidence at this time.

THE COURT: Received.

Let me mark it.

(Federal Exhibit E was received in evidence.)

Q Mr. Budoff, would you tell us something of the substance of the letter, Government's Exhibit E.

THE COURT: Look, we don't have a jury here and I don't want this to become overformalized. Just tell me what it is about. It is in evidence. I can read it. What do you want me to know?

MR. O'CONNOR: What I want you to know is that from the previous letter there are certain exhibits, etc., that the state was supposed to have forwarded and they did not. The letter indicates that Mr. Budoff is asking them to forward what they previously said they would.

THE COURT: Is that right?

THE WITNESS: Yes.

THE COURT: Okay.

MR. O'CONNOR: I have no further questions at this time.

THE COURT: Well, stay there, because I would li to ask a few more questions.

BY THE COURT:

Q You heard Mr. Fine say that whatever the regulations say, although he argues that they mean different thing than what your lawyer says, that the fact is that the government has always allowed the state to go ahead on the impleme tation of its amendments and if I understand Mr. Fine correctly, that is, and has never held them up, penalized them or anything else, even if they hadn't been approved.

Do you know whether this is the case? Do you know of any instance in which -- well, do you know if that is the case? I guess that is the best question.

A Your Honor, procedurely, what would happen in an instance where the state had implemented a regulation or implemented material that required a plan approval from us and which they had not recieved, our action would be to make a recommendation that they be found out of compliance.

Q Have you ever done that?

A Yes. There have been a number of areas where th state has been found out of compliance. I don't have specific knowledge at this time as to whether or not the material submitted by Mr. Fine led to such a compliance recommendation.

Q Let's take the three matters that are in issue here.

If the Court does not prevent the state from putting them into effect prior to your approval and the state does put them into effect or keeps them in effect -- I guess they are -- what will you people do about it?

A Well, if the state were to put this into effect absent our approval --

Q Let me ask -- are the regulations in effect at the moment or not?

MR. FINE: As far as the state is concerned, they are.

MR. IMBERMAN: If your Honor please, what has happened is rates have been promulgated based on these regulations.

THE COURT: That's what the regulation says. I am not saying what factual result would happen.

The state takes the position that their own regulations are in effect. It really means yes, we think we have done everything we need to proceed.

THE WITNESS: We would, in our quarterly compliance report --

Q When is that?

A I am sorry, your Honor, I don't know if it is th beginning or the end of the quarter, but there is a quarterl compliance report.

Q Calendar quarter?

A Fiscal quarter.

Q That is the same quarter?

A The federal fiscal year is beginning September 1st, this year.

So it is not necessarily a calendar quarter. But we would find that the state is out of compliance in this area.

Q What would the effect of that finding be?

A That would be a recommendation that we would make The administrator would then have to make a finding or rule that the state was indeed and in fact out of compliance, at which point there would be a compliance hearing.

Q You really don't need to go further. I can see the bureaucratic machinery working and the point is, even if you find them not in compliance, the house won't come tumbling down in a few days or weeks, is that right?

A That is an accurate assessment.

Q Now, the other question was this:

In your testimony and in your affidavit, you have indicated that there were certain areas of the proposed new amendments that are at issue in this proceeding that you wanted to discuss -- and I say you collectively, HEW -- wanted to discuss with the state. Do you know what those areas were? And I think you said in your testimony that the had raised questions in the mind of HEW as to how or whether the proposed amendments would produce a reimbursement of the reasonable cost of medical services.

Is that one of the questions you wanted to talk over and if so, could you be more detailed in saying what the questions are?

A The problem thatwe have is that the state has submitted to us their regulatory material. Now, in order for us to make a determination as to whether or not this would lead to a reasonable reimbursement, we require further clarification on a number of things.

It is the responsibility of the state not only to promulgate regulations but to be able to support their position that these will lead to a reasonable, a reimbursement of reasonable cost.

One of the problems that we have is that we have the regulatory material but we do not have any of that back up analysis and one of the things we wished to discuss with the state is for them to be able to show us how this will lead to a reasonable reimbursement.

Q In effect, you are not suggesting that you have taken any tentative position on the merits, but just that you need more information?

A Right. That these are the areas where you have to satisfy us that this will indeed and in effect lead to a reasonable reimbursement.

THE COURT: Mr. Fine, do you have any questions to put to Mr. Budoff?

MR. FINE: No. I just want to ask one question.

BY MR. FINE:

Q When you spoke of the state being not found out of compliance, you understand the state plan embraces not merely part 86 of the Code of Health Regulations dealing with the form of reimbursement but the state plan also embraces a great many other problems, having to do with eligibility, the nature of services to be rendered, it covers a broad spectrum of requirements, much of which is not within the jurisdiction of the Health Department, but is primarily the responsibility of the Department of Social Services, so they might have been found out of compliance on other matters not having to do with the method of reimbursement, the methodology by which hospital rates are computed?

A That's correct.

Q In other words, do you recall specifically any case in which the state has promulgated a regulation in which HEW has found them out of compliance by virtue of the regulation not giving the hospital reasonable cost, rememberi always that the New York State plan is a plan for prospectiv reimbursement?

Do you recall any? You don't have to but I just wondered if you did.

A I am not specifically aware of any such instances.

BY MR. IMBERMAN:

Q Mr. Budoff, would it fall within the purview of your office to make a determination as to whether a state plan provided for reasonable cost?

THE COURT: Could you read the question back?

Q I will rephrase it.

Would it come within the scope of the activities of your office to make a determination as to whether or not specific amendment to a state plan would or would not result in the hospital's receiving reasonable cost reimbursement?

A Is your question directed to hospitals generically or directed toward the instance that a particular hospital gets reasonable costs reimbursed?

Q Well, the plan itself is not addressed to specific hospitals; it is a plan that is applicable to all hospitals.

Now, suppose an amendment came through to a state plan which said, all hospital rates are frozen as of

1974 rates, and that becomes effective July 1, 1976.

Would it be the function of your office to decide whether or not that amendment did not produce reasonable cost?

A With regard to that hypothetical amendment?

Q Yes.

A With regard to that hypothetical amendment on the face of it, a freeze at a level would indicate that reas able cost was not being reimbursed.

THE COURT: We are not asking about the merits. We are asking who in your outfit decides this.

Q Is it your office that determines it or somebody in Washington or do you make a recommendation?

A The delegation for the approval of plan material resides in the regional office. The delegation for disapproval of plan material resides in the central office.

We would make a recommendation to the central office and they would have to make the ultimate determinatio as to whether or not that--

THE COURT: If there was to be a disapproval?

THE WITNESS: Yes.

Q So, if a freeze regulation or a freeze amendment came through, I take it you would automatically say, this do not produce reasonable cost and you would recommend non-approval? Am I correct?

MR. O'CONNOR: Objection, your Honor. It seems to be a leading question.

THE COURT: I would rather stick with the facts of the case, instead of a hypothetical.

Ask about the facts of this case, please.

Q Would you be prepared to make a recommendation on the 100 percent average limitation, which is one of the amendments in this plan or do you need more material?

A I think there is the obligation of the state to satisfy us that that does not contravene reasonable reimbursement to hospitals.

THE COURT: In other words, at least to the exte of your expertise on the subject, you do not equate the 100 percent average formula that is being proposed with automatic freeze?

THE WITNESS: No.

THE COURT: The witness previously said a freeze was bad on its face and would be disapproved and that he does not equate the state's present proposed 100 percent average with a freeze as being bad on its face. It may be bad or it may not be bad, but it is not bad on its face; is that right?

THE WITNESS: That's right.

Q Have you asked the state to supply you with additional information concerning how that regulation is going to work?

A We have requested meetings with the state to go into the areas where we have questions, that is one of the areas we identified that we did have questions around.

Q Have you asked for specifics or have you just said "We would like to meet and discuss it with you"?

A The request was a generic request, that we woul like to meet and discuss. But we supplied them with a list of the materials that we had questions to and asked them to be prepared to respond to our concerns around the identified materials.

Q Do you have a copy of what you sent to the state?

THE COURT: Isn't it in one of the exhibits? All the letters back and forth?

Who has the exhibits, C, D and E?

MR. O'CONNOR: I do, your Honor.

Q Is that what you sent the state? What was just referred to?

MR. O'CONNOR: I think that your Honor has E.

THE COURT: Yes, I do.

(Documents handed to witness.)

(Pause.)

A Exhibit B is the cover letter that there was an attachment to and the attachment was the material that we had prepared in matrix form.

THE COURT: And it is the one that expresses your concern about the subject of 100 percent?

THE WITNESS: One of the items that we had some questions about.

MR. O'CONNOR: We don't have that attachment at .s time, your Honor.

MR. IMBERMAN: Is it procurable this afternoon?

MR. O'CONNOR: Yes, it is.

MR. IMBERMAN: Perhaps we might get it, your Honor. At least I would like to have an opportunity to look at it.

Q Mr. Budoff, if a man limits the amount of money which a hospital receives arbitrarily so that it does not receive whatever it has spent to efficiently produce the hospital services, would that plan produce reasonable cost reimbursement?

MR. FINE: I object to that question.

THE COURT: I think it is objectionable, althoug I am sure Mr. Budoff is well qualified to answer.

Q Are those points raised in the attachment to the letter that you referred to? The questions with regard to the 100 percent average limitation on costs.

A That is one of the areas that we have questions around.

MR. IMBERMAN: If Mr. Budoff would stay until this afternoon when I get a chance to look at it --

THE COURT: When you say "stay until this afternoon," I hope nobody will have to stay. If you want to look at what Mr. O'Connor has --

MR. IMBERMAN: He does not have the particular document.

MR. O'CONNOR: Your Honor, we have no objection to supplying it. At least I don't see why Mr. Budoff should have to remain.

THE COURT: I don't either at this stage of the game.

MR. IMBERMAN: Subject to what I look at, I might want to ask questions. I would like to look at it.

THE COURT: Well, does anyone here have it? It seems there may be a copy of it here.

MR. O'CONNOR: We are not sure if this is it, your Honor, and we prefer to make sure.

THE COURT: All right.

Thank you very much, Mr. Budoff.

BY MR. FINE:

Q Mr. Budoff, assume the state supplies you with the material you have requested to substantiate the fact that these new regulations comply with the statutory requirements the hospitals receive in-patient, the cost of furnishing in-patient Medicaid care. In your opinion, are the regulations, assuming the state again gives you the material you requested, in your opinion, and I assume that you have had some expertise in this field, are these regulations approvable?

I am not asking you to state whether they will be approved but whether they are approvable.

MR. IMBERMAN: I object to that. It is highly hypothetical.

THE COURT: Maybe so, but I am going to assume, Mr. Imberman, on the present state of the record, that they are approvable because as I see the word "approvable," if they weren't, then it seems to me that the Department of HEW would have written back and said what you have submitted to us cannot be approved under any circumstances.

That is not the position you took, is it? The position you took as I understand it, is you did not know whether it could be or could not and you wanted more information.

THE WITNESS: That's correct.

THE COURT: So I construe the situation as being one in which the regulations are approvable but they have not been approved.

MR. FINE: Thank you, your Honor.

No further questions.

(Witness excused.)

THE COURT: Mr. Fine, I take it that Dr. McCann has arrived?

MR. FINE: Yes, I think he has.

WILLIAM F. MC CANN, called as a witness on behalf of the State, having first been duly sworn, testified as follows:

THE COURT: Doctor, I am sorry to have brought you all the way down from Albany.

THE WITNESS: It is all right. It is not "Doctor."

THE COURT: Commissioner -- all right.

But there were some questions that I had as a result of your very interesting affidavit. I will let Mr. Fine ask the questions first and then if I am not satisfied, I will ask the questions.

EXAMINATION BY

MR. FINE:

Q Would you state your duties?

A I am head of the Division of Health Care Cost Control. We compute the reimbursement rates under the Medicaid program for hospitals, nursing homes. We have an input into the fees paid to practitioners. We review the Blue Cross reimbursement formulas, the rates, handle all appeals from the Medicaid reimbursement rates that are established, audit with our own staff and long term care facilities, in conjunction with the Blue Cross plans, the hospitals throughout the state.

Q And in the course of your activities, you have occasion, I suppose in connection or association with the Commissioner of Health, to issue and promulgate regulations as part of 86-10?

A Yes.

Q You are familiar with the recent correspondence and the recent regulations between the state and HEW about these new regulations.

Now, Mr. Budoff in his testimony referred to the word "matrix."

Can you explain that further? As I understand it it was a request by the HEW for a body of information or material substantiating the new regulations. Am I correct about that?

A That is correct, sir.

Q And can you tell me a little bit about that matrix?

A Yes. The Department of Social Services, being the single state agency for the administration of the medica assistance program has the direct contact with the Department of Health, Education and Welfare through the regional offices.

The material that we prepare in the Department c Health that has to do with the reimbursement aspects of the program, are forwarded to the Department of Social Services where they are then forwarded with other additional material possibly, to the Department of Health, Education and Welfare

The review conducted in the regional office of any state plan material, often prompts many questions as to the intentions of the state, the impact of any proposed regulation and they will go back to the single state agency and raise these questions, even though the questions may be more properly answered by the Department of Health.

When this happens, in most instances, I believe the Department of Social Services contacts the people in th Health Department and we get together and each department frames the answers that it has expertise in.

In this particular case, the matrix came in from the regional office of HEW to the Department of Social Services. Since there were many areas that were the primary concerns of the Health Department, I was asked to sit down with people in Social Services and discuss the items one by one on the matrix and then propose the answers from the stat to the federal government.

What the matrix really did is identify those particular areas by number of the proposed regulations that the federal government felt they had some problems with, either through lack of understanding, lack of clarity, need of more background and so forth.

One of the items of course was Section 80-14(b) and this is --

THE COURT: Is that the average cost question?

THE WITNESS: Yes.

A And I do not have the matrix here. If I remembe it correctly, the question that was specifically related to the average cost question was one word, whether we meant over or above, and let me explain a little bit:

When we were developing that particular regulation, at the time we were drafting it, we left a blank because we had not yeter determined the particular percentag of average cost or lower than average cost that would be applied as a ceiling.

Consequently, we used the words, and I am doing this from memory, that the ceiling will be limited to blank overweighted average costs.

When the determination was made that we would use average costs as the base, someone with a pen stuck "100 percent" in. If you read it with 100 percent, it sounds like 100 percent over average costs, it sounds like 200 percent, which of course it is not intended.

But the question that was raised was not about 100 percent or whether we went 100 percent over average costs or 100 percent of average cost. That is my recollection of that particular area of the matrix.

So I did not think of that as being a material question that would require statistical --

THE COURT: Mr. Fine, I don't know whether you are asking questions along these lines and Mr. McCann is giving answers along them, because I think that this is the area that I am interested in as a result of the affidavit, and if so, it is not.

MR. FINE: I won't ask any further questions and leave it up to your Honor.

Q As I understand it, the words, "100 percent of" were deleted and the regulation as now before HEW, simply uses the word "average."

A Yes.

Q Could that be accomplished by saying 100 percent of average cost and -- that in fact is corroborated by Mr. Budoff's affidavit.

BY THE COURT:

Q You say on page 9 of your affidavit, paragraph 24, you say:

"Hospitals have generally failed to respond to the State's cost control efforst and the average annual rate of increase in per diem costs in New York State hospitals from 1970 through 1974 was 11.98 percent."

I wonder whether you mean, first of all, by sayi they have failed, and second, what you meant by saing they have failed.

You mean they did not come in with services as cheap as the state hoped, or that they were actually chargin the state more than the true costs? What do you mean?

A Under our prospective rate system in New York State, we attempt to set in advance the levels of payment under the Medicaid program and the levels of payment under the Blue Cross plan as set by Blue Cross, and approved by the state.

When we set the prospective rate, it is based on the historical certified cost reported by the hospital, subject to whatever ceilings were in effect at the time and then those costs are projected forward, using the best indicators of inflationary trends that we can put our hands on and relating those inflationary trends to the types of expenditures that the hospitals have.

So the theory behind the prospective rate system was to establish the parameters within which we would expect the hospital to operate.

When I say that hospitals have generally failed to respond, what I mean is some hospitals have responded.

Q Then I understand the word generally.

What do you mean by "responded"?

A Respond by having our rates influence their cost patterns, so that their cost increases from year to year parallel the inflationary trends that we were setting --

Q I can't understand how your rates would influence them.

The word cost is cost, it seems to me.

A Yes. However, in New York, between the Blue Cross Plan and the Medicaid reimbursement system, we have better than 50 percent of the hospital's business, under a prospective cost control formula and when the resources are made available to the hospital, are requested, we would normally expect the hospitals to react by doing something with their expenditures.

Q All right. I understand what you mean by that.

The next question is on page 11, paragraph 29, and there you say:

"An analysis of 1976 rates for voluntary hospitals indicates that 83 are receiving a rate in 1976 that is lower than the 1975 rate. Of the 83 hospitals, 15 were not affected in any way by formula ceilings while 54 of the hospitals affected by ceiling penalties had disallowances which amounted to less than 2 percent of the hospitals' in-patient costs."

I take it that that means that even though the rate structure, acknowledgedly -- or the ceiling is lower in '76, there are 15 cases in which that did not have an adverse effect, is that correct?

A That's correct. The application of the formula produced no ceiling limitation.

Q And then the result of the total analysis is, I guess, is that only 9.6 of the voluntary hospitals which w affected by ceiling limitations had an overall cost reduction impact greater than 2 percent of in-patient costs?

A Your Honor, I have a schedule that certainly everybody can see, that shows the breakdown of the percentage of penalty as related to the in-patient costs and the names of the hospitals affected.

THE COURT: I will leave it to counsel whether they want to go into that detail or not and I just wanted to be sure that I understand your statements.

I was the one who asked you to come down, so I assume they do not disagree with the facts you have stated here, but we will see.

Q You do say in paragraph 30 that two of the particular plaintiffs were not affected, is that right?

A That's correct.

Q I don't think the case turns on that basis, but it is interesting.

A Yes.

Q What is your implication in the last two sentenc of paragraph 31? There you say:

"The plaintiffs' position appears to be that if immediate relief is not granted, the hospitals have no alternatives other than to immediately reduce the quantity or quality of services below acceptable levels." And of course, that is an important question, particularly if I am ruling on a preliminary basis.

Then you say:

"In no way has it been established that the plaintiffs have no other option."

One can imagine what you have in mind. What options does the state believe that the hospitals have if th do not get the money for the timebeing?

A We are talking here of the 83 hospitals that I mentioned in paragraph 29, and 39 of them fall between the 1/10 of 1 percent category of in-patient costs.

Q Is that specified in your affidavit. It is in your affidavit?

A IT is in the exhibit.

THE COURT: Why don't we make that a Court exhibit.

MR. FINE: May I offer that in evidence, then? May I see it?

THE COURT: We will make it a New York State exhibit.

MR. IMBERMAN: Your Honor, may I see it before i is received in evidence?

THE COURT: Yes. Here is a copy (handing).

(State's Exhibit E was received in evidence.)

Q And you were referring to the second item.

A Yes. Where the penalty is a percentage of in-patient cost in 39 of them fall between the 1/10 of

1 percent and another 15 fall between 1 percent and 2 percent and 15 out of the top, that means out of the 83, tha means that there are 14 of the voluntary hospitals - may I say I am only talking about voluntary hospitals --

Q That is all we are concerned with.

A Of 14 hospitals reflected greater than 2 percen in-patient costs.

Now, in studies that we have made over the years and I am sure that the same would be true in studies that ma have been conducted by Blue Cross, in some years the Medicaid rate of payment in hospitals may be 2 or 3 percent under cost. That is the way the formula works.

In other years, the possibility is that the Medicaid payment may be over cost, again, with the prospective system and it just seemed as though a hospital with a less than 2 percent or 39 hospitals with less than 1 perc on total in-patient cost -- well, it was inconceivable to me that a hospital would have no option other than to start dropping off services and quality of care.

When you talk about one patient on in-patient cost, you might as well be talking about one employee out of 100 and it just seems as though there would be other options available.

Q All right. I understand that.

The next question I had is this:

On page 12, in the middle of paragraph 34, although I understand the literal words, I would like to hav more detail.

You say:

"In New York State, hospizals have been very carefully grouped as to size, area, type, charateristics, and other relevant factors. Therefore, a rigid ceiling is appropriate."

Therefore, I take it what you mean is the closer a definition of a hospital, the more appropriate an average is as a method of --

A That's correct. If you use a very broad definition and let us assume that you took all the acute care hospitals in the City of New York and you said, "This is a group," and even break it down by size, in order to have the reasonable cost attainable ceiling, the ceiling would have t be maybe 30 percent.

Q I understand that. To what extent is the methoo of defining groups changed this year in the light of the change of the cost formula?

A It has not changed.

Q You just meant that even if it had changed, it was already sufficiently narrow to justify an average appro

A Let me clarify that a little. When I said it ha not changed, I think I should have said it has not basically changed to restructure all the groups.

There will be certain groups where individual hospitals have been switched, but there has been no general overall restructuring.

Q The next question I had is on page 31, paragraph 38, you say:

"In determining an appropriate ancillary cost ceiling the Department of Health selected a case method,, rather than a per diem method."

And that I don't understand, because I don't understand the terminology.

A Let me explain it this way:

The payment system used under Medicaid and under Blue Cross is on a patient day basis. This is the reimbursement available to the hospital for patient day service.

In routine in-patient services, one can generall say that the patient receives roughly the same services regardless of how long he stays in the hospital and regardless of his particular illness, room, board and floor nurses generally.

When you get into the ancillary service departments it is a completely different situation.

For example, suppose you and I have to go to the hospital for the same particular procedure and you are healthier than I am and you stay five days and I stay ten days.

With the same particular procedure, the chances are you will receive the same ancillary services. Let us assume the ancillary services cost $100. On a per diem basis, the $100 of anciallary services is $20 per day in your case for the five-day stay and $10 in my case for the ten-day length of stay. So theoretically, you will be affected by ceiling on a per diem.

If we say instead, let's look at the discharge, and you are discharged and I am, it costs $100 for ancillary services for me and $100 for you.

Q So what you are talking about is the discharges?

A That's right.

Q Next, paragraph 39, there you say, the first sentence:

"The Department recognizes that individual hospitals within a group could certainly have costs in excess of average costs for a group that are completely justified."

That is a refreshingly frank admission and I wonder what the state's position is as to what ought to be done in such cases.

A Yes. We could take all of the major teaching hospitals in the City of New York, hospitals about the same size, about the same teaching programs, located in the same economic area, geographic area, and in one or two of these hospitals, you may find some significant differences that could not be taken into consideration in developing a group. They are a pretty sold economic group. But when you start becoming concerned with the patient mix, the age of the patient, unusual services in one particular hospital as opposed to others, the volume of service, certain services in one particular hospital as opposed to others, you do find cost variances and justified variances.

A simple example --

Q You really don't need to give me an example. I had a day of testimony on this before from a gentleman who I am sure you will agree is competent.

What do you generally do when that occurs?

A What we have done is not the processing of an amendment -- let me go back just a little bit.

In part 86, we have an appeal procedure that specifies the particular circumstances under which the Commissioner of Health can establish an appeal.

The appeal procedure has now been filed with the HEW and does not -- I beg your pardon. This was just recently filed.

Prior to this amendment, the appeal procedure did not provide any basis for the Commissioner to honor an appeal on the basis of a ceiling limitation. We recognize that the use of the average cost as a ceiling limitation would produce certain cases where it is just wrong; it shouldn't be applied to certain hospitals.

So we now have an amendment to our appeal procedures which states, for such relief -- this is 86-71-7. The last page of the affidavit.

What it says is for such relief a medical facility must demonstrate that its range of approved service patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the routine or ancillary ceilings.

Q I am sorry, you say it is part of your affidavi

A The attachment.

So what we are really saying is that certainly some hospitals are going to be affected by the ceilings that we have established and when you get into the area where they are affected by 4 percent or 5 percent --

Q Let us take the situation like Mount Sinai, which is well-known to you, I am sure, and as to which Dr.

Pomrinse testified that they will be adversely affected and he estimates to the extent of $2,000,000.

Now, assuming that they believe they are eligibl to appeal under the criteria that you have established, can they appeal right at this moment?

A Yes,they can.

Q And what do they have to establish to your satisfaction and how do they do it, to recoup?

A Mount Sinai is grouped with the large teaching centers in the City of New York since they are affected by a penalty to, I think Dr. Pomrinse's statement was $2,000,00 and I am sure he is right.

Q Is $2,000,000 of what they received last year or $2,000,000 below reasonable cost, presumably, is that right?

MR. IMBERMAN: No. The difference, I think Dr. Pomrise testified, between their cost and what the rate would be was about $2,000,000.

A Fine. But looking at the schedule I have, it shows Mount Sinai with a 2.7 percent penalty of in-patient cost and if I am not mistaken, Mount Sinai's in-patient cost would come close to --

Q That is close to 2,000,000.

A That's right. It is close, so since Mount Sinai is affected by a penalty, when compared to the group of large teaching hospitals in the City of New York, this means that Mount Sinai is doing one of two things --

Q Wait a minute. It has not been established on the record that they are, if I understand this correctly and anybody is free to correct me if I am wrong, what has been established is that they =estimate that what they get from the state will be $2,000,000 less than their reasonable costs. That is not necessarily the same as saying, is it, that payments are less than 100 percent average.

Indeed, they will be 100 percent average; right? So how do you determine penalty?

A Your Honor, isn't that the same thing? If Mount Sinai Hospital was not being affected by a penalty, then one could say they would be receiving full costs.

Q I don't know what your definition of penalty is. If you simply mean that the adverse effect of this regulation is called a penalty --

A That's correct.

Q Then I understand. And it's not in comparison to the other hospitals, it seems to me. It is in comparison to what their own costs are.

A Well, the hospitals' own costs really form the basis for the penalty, when compared with the peer groups.

Q Explain to me what your procedure is. Dr. Pomrinse comes to you and says, "I have a 2.7 penalty."

A All right, Dr. Pomrinse has a 2.7 percent penalty of in-patient cost and let's say it is $2,000,000 just for conversation.

The penalty was determined by comparing his costs with the costs of teaching hospitals that are the same size and so forth.

Why is Dr. Pomrinse suffering a penalty in Mount Sinai? I can't answer the question. All I can say is his cost pattern is different for some reason. I think it is up to him to say "I am different from these other hospitals because I have these particular" --

Q He says "I have a great new building I just approved and I need money to run it and so forth."

I agree with you in theory that they have the facts, so it is not unreasonable to ask them to give you the facts and suppose he has given you all that material.

A If the hospitals can justify the differences in their costs as compared with the hospitals that they are grouped with, they will have their appeals honored.

Q Now, this is a very interesting thing because in reading your papers at home on Sunday, when I get the bes work done, I made a note that it seemed to me that the new approach of the state is to some extent a shifting of the burden -- that is, that you arenow asking people to show you why they should get more than average and you are asking them to establish that.

A It is not so much, your Honor, of shifting the burden, because we always felt that the burden was on the facility. It is focused a little sharper.

Q I think I have asked you all the questions I wanted to, but let me check.

In paragraph 41, with regard to the requirement of Public Health Law or rather, with regard to the regard of the State Hospital Review and Planning Council, as I understand it, you asked them to approve what you did and they did not and it is not quite clear to me as to what you or Mr Fine consider to be the legal significance of their disapproval.

Is it implied that you think all you have to do is ask them and then whether they approve or not is irrelevant, or what?

A Your Honor, not being an attorney, I would prefer to have someone else answer that.

MR. FINE: May I answer, your Honor?

THE COURT: Yes, will you?

MR. FINE: Section 2807 subdivision paragraph 3 of the Public Health Law of the State of New York, specifies specific factors which the Commissioner of Health is to take into consideration in fixing rates, such things as comparabl groups of hospitals, size of hospital, location and so forth.

THE COURT: And the cost of educational --

MR. FINE: The very last sentence of the paragraph says that the Commissioner shall exclude so much of educational costs and teaching factors -- I will have to get the exact language -- as in his discretion he shall deem appropriate and acting under that specific language, whether or not they approved or disapproved, the Commissioner exercise his authority and promulgated the regulation by which h said that 10 percent of the costs of the salaries of residen and interns shall not justifiably be included in the costs of hospital operations upon which rates shall be computed.

THE COURT: And what you have just said applies, that the Commissioner did not require the approval of the review --

MR. FINE: That's right, because the statute is explicit.

THE COURT: Where does the role of the, as you put it, of the Review and Planning Council originate? Is that by regulation or statute?

MR. FINE: By statute, but it does not require-- for instance, the Review Committee Council, does not have to go into the question of the groupings of hospitals, it does not have to go into the question of areas --

THE COURT: I guess I will have to look at the statute.

MR. IMBERMAN: I would like your Honor to know this and I know this comes awkwardly in the middle of a witness' examination, but I feel compelled --

THE COURT: Go ahead.

MR. IMBERMAN: Your Honor has to read Section 2807 very carefully to read the precise language about educational salaries. I think your Honor should know that the administration introduced a bill in the legislature this year directly on this 10 percent reduction of the cost of interns and residents.

The legislature deferred to pass it.

Then they went to the State Hospital Review and Planning Council and decided, well, we will do it by way of a regulation and the council has to, according to law, pass the regulation.

The council refused to do it twice and it was only then when the Commissioner insisted that he was going to cut this out, that he did it on his own and said, "I have the authority, regardless of what the legislature and the council did," and he does it by his own authority.

THE COURT: Thank you. I believe I have finished my questions to Mr. McCann.

MR. FINE: I just wanted to correct one observation.

The reason the legislature did not pass the bill on which my learned colleagure referred, was that they were advised that it would be done by the Commissioner of Health.

CROSS EXAMINATION

BY MR. IMBERMAN:

Q Mr. McCann, did the Department of Health issue rates for reimbursement to the hospitals for Medicaid-paid hospital costs of 1975?

A Yes.

Q And were those rates supposed to represent the reasonable cost to the hospitals of providing service?

A Yes.

Q Now, in computing the 1976 rates you used a trend factor, didn't you, which you applied to basic rates?

A Yes.

Q And is it true that that trend factor was supposed to compensate for the cost of the inflation, the increase in hospitals' costs over the year?

A Yes.

Q These were costs over which tyey had no control, am I right, because of inflation?

A On the direct expenditure side, yes.

Q What was the trend factor for, say, the New York teaching hospitals for 1976?

A Mr. Imberman, I don't have those.

Q Let me suggest to you 8.65 per cent. Does that sound familiar to you?

A No.

THE COURT: No, it does not?

THE WITNESS: No. May I clarify it?

THE COURT: Yes.

THE WITNESS: Under the Medicaid system we trend for two years, from '74 to '76; we trend first to go through the intermediate year of '75, which was a little different than was described for Blue Cross the other day, and then we figured for '76.

The figure that seems to ring a bell to me for 1976 -- and this is trended from 1974 -- I think was somewhere in the neighborhood of 18 per cent.

Q Which included a two-year --

A Two years.

Q And in the computation of the two years wasn't there somewhere in the arithmetic that you did some sort of computation of what '75 to '76 would be?

A Yes.

Q And wasn't that about 9 per cent?

A Yes, I think it is probably close. I do not have the papers.

Q Well, let me ask you this: Isn't it true that the Department of Health expected that the hospitals' costs of operations -- let's limit ourselves to New York teaching hospitals -- would go up in 1976 over 1975 in somewhere about 9 per cent?

A On the basis of our indicators, yes.

Q Now, you actually issued your rates on July 1st or July 2, 1976, am I right?

A In that time frame some place, yes.

Q By that time didn't you already see from what had happened in the year that the hospitals' costs were going up so that your 9 per cent expectation at the beginning of the year was being fulfilled?

A No, I wouldn't say that, Mr. Imberman.

Q Do you have any figures on that? Did you make any studies on it?

A No.

Q This is just off the top of your head?

A Not completely. For example, if I may give you an example --

Q No. Mr. McCann, I would appreciate it if you answer the questions.

If you say no or yes, that's an answer. If I want an explanation I will ask for one.

Let me ask you this: In connection with the 1976 rates which the department promulgated, did the Department of Health make any study from which it determined, for example, that the cost of treating Medicaid patients at Mt. Sinai Hospital would decline by about 6 per cent over last year?

A No.

Q Did the department, in connection with the rates which it promulgated for 1976, make any study which showed that the costs of treating Medicaid patients at the New York University Medical Center would decline about 10 per cent?

A No.

Q In connection with its 1976 rates did the department make any study which determined that the cost of treating Medicaid patients by any voluntary hospital in the state would decline this year as compared to last year?

A No.

Q In connection with the promulgation of its rates did the department make any study which showed that any item of costs in the voluntary hospitals during 1976 had been or would be incurred in an unreasonable manner?

MR. FINE: May I ask that question be restated? I didn't understand it.

(Question read.)

Q I am asking you that question in relation to the concept of reasonable cost that is in the Medicaid statute.

MR. FINE: I object to that question. It seems to be not only confusing but I don't know if it can be answered.

THE COURT: He can answer it by saying he didn't make any such studies.

I take it what Mr. Imberman is trying to find out is whether the state has any studies that show that the costs had been inflated anyway.

MR. IMBERMAN: Or unreasonable in the context of the Medicaid statute, which talks about reasonable costs.

A Would you like me to speak to the reasonable cost of the issue?

THE COURT: No. He would like to know whether you made any special studies on it. Let's call spades spades.

The state presumably believes -- and I assume this -- that more money is being spent to provide services that are being rendered than necessarily needs to be spent.

Am I fair in assuming that that is the attitude of the authorities of the state?

THE WITNESS: Yes, sir, any ceiling.

THE COURT: Well, the ceiling at least might say, "Look, if you spend more than that you do it on your own." But where the requirement is that you must pay reasonable costs, then if you establish a ceiling you are implying that anything more than this is unreasonable.

THE WITNESS: That's correct, sir.

THE COURT: And Mr. Imberman is simply saying did you make any studies as to that that found that certain things are unreasonable or was it the overall level of costs that led you to the conclusion or what.

THE WITNESS: I think, your Honor, the best way I can answer the question is in --

MR. IMBERMAN: If your Honor please, I think I would like to have an answer to the question.

BY MR. IMBERMAN:

Q I want to know whether the department made any studies to show any unreasonable costs.

THE COURT: Any specific studies.

A I have trouble because I am not sure whether an analysis is considered a study.

THE COURT: Tell us what there is.

Q Have you got something in writing?

A This is what I was attempting to do.

Q Does the department have anything in writing which you could call an anlysis or a study or anything else which showed that hospitals, the voluntary hospitals, in the State of New York had incurred costs in an unreasonable manner?

A Mr. Imberman, I don't like to be sort of dense, but you use the term "unreasonable" and "reasonable" without defining your definition or mine.

Q Reasonable costs as defined in the Medicaid statute which you have been living with for many years, Mr. McCann.

THE COURT: Well, let's say approximate actual costs.

MR. IMBERMAN: All right.

THE COURT: That's what the court decision is so far, is it not?

But let's say -- I don't care. I am willing to take your definition of reasonable.

MR. IMBERMAN: Well, I would like an answer to the question first, your Honor, and then if he wants to expand on it we will see.

A I'll answer very quickly.

THE COURT: What have you got? Never mind his definition. You have something in mind, apparently, and whatever it is, tell us.

A Fine. Let me. In 1976 the department reviewed its reimbursement methodology --

THE COURT: It's own?

THE WITNESS: It's own reimbursement methodology.

A -- and took a look at the ceilings being used and many things in the reimbursement formula to determine whether the application of that formula actually produced costs that were related to the efficient production of services, which is in the state law.

Now, in looking at this we made a determination that it did not and that when we first started the formula as I mentioned in the affidavit it was not a one-year or two-year thing, it was a long-range program.

During the years there are many things that deterred the department from making changes in that formula, ancillary services,for example. We didn't have one.

MR. IMBERMAN: If your Honor please, I don't think I am getting an answer to the question.

Q If you have specific studies or something, fine, but you are talking generalities.

THE COURT: It is not generalities, but the studies that you have made, as I understand it, you haven't studied a particular hospital or group of hospitals which state that the costs that they are in curring or charging us are not the reasonable costs of the services they provide, have you?

Have you done anything as specific as that? I have no reason to believe you haven't or have --.

A Only two groupings. In other words, we have an analysis of all the hospitals in the state grouped with their peers, looking at the range of their costs as comppared with other costs.

THE COURT: You have?

THE WITNESS: That's an analysis and I don't know whether that comes into his definition of studies.

THE COURT: Never mind.

A Every hospital grouped with its own costs, seeing how far they range from the average in that particular group we have looked at or traced hospital costs from over periods of years, showing what the costs went up as compared to the increase in our rates, inflation factors.

THE COURT: In doing all of this comparative analysis, how have you done it? Is it simply that if a hospital -- I know, for example, your ceiling was 10 per cent above 100 per cent --

THE WITNESS: That's correct.

Q If you had a hospital that was 20 per cent above 100 per cent did you and your analysts say, "Well, 20 per cent above is almost certainly unreasonable," and let it go at that, or did you inquire into what was happening at that hospital and inquire whether it was over 20 per cent over?

A This gets back to something we discussed before, the burden of proof and that hospital would be affected by the ceiling at the 110 per cent level of the prior years. It is then up to that hospital to make its own --

THE COURT: Did hospitals ever do so?

THE WITNESS: Yes, certainly, constantly.

THE COURT: Did you ever conclude that any particular hospitals were unreasonable, that their costs were not reasonable?

THE WITNESS: Yes. That would be concluded by our denial of an appeal.

THE COURT: Was that true of any of the hospitals that Mr. Imberman has asked you about, the New York State teaching hospitals?

MR. IMBERMAN: The only two I asked about were Mt. Sinai or New York University, and that was 1976, and that's all I asked.

THE COURT: Well, let's go on.

Q You told the judge just a little while ago that you had statistics on hospitals and you compared their costs with their peers and their peer groupings and you would determine that some hospitals had higher costs than others, am I right?

A Yes.

Q If you found a hospital that had a higher cost than another hospital that you thought was comparable, what would you do?

If in the studies that you just mentioned to the judge you would find that hospital A might have a higher per-diem cost than hospital B which was within its peer group, what did you do?

Let me withdraw that and say at what point did you consider the difference unreasonable?

A In 1976 we considered it unreasonable when the cost went over the average cost for the group.

Q But you haven't looked at any hospitals for '76 on 100 per cent averages, have you?

A We are looking at 1974, which is the basis for the '76 reimbursement.

Q But my question to you is what did you do if you found a hospital that had a higher cost than another hospital?

A In 1974?

Q At the time that you mentioned to Judge Lasker you made the studies and you compared costs. Did you do anything?

A These are 1974 costs and the hospitals were analyzed to make a determination as to the appropriate ceiling which should be placed on 1974 costs.

Q Did this happen in the year 1974?

A Oh, no. It happened in late '75.

Q Let's take in the year 1974. If you looked at the costs of hospitals and you found a hospital which had a higher cost than one in its peer group what would you do?

A Sir, I can't answer that question. 1974, in that year, we would not have hospital cost data. We wouldn't have the hospital costs --

THE COURT: I don't understand Mr. McCann to have said or say that they do anything. They get this information for the purpose of developing policies and he says that it is not up to them to do something if the hospital spends too much money, the ceiling will stop them.

THE WITNESS: That's correct.

THE COURT: And if the hospital thinks something ought to be done, they are supposed to come to you, is that correct?

THE WITNESS: That's correct.

THE COURT: Let's assume, however, a case which Mr. Imberman has not necessarily posited. Supposing a hospital's actual costs are 95 per cent of average or 90 per cent of average, which they get out of it it anyway, don't they?

THE WITNESS: No, sir, their own costs.

Q I mean if they are below average --

THE COURT: I don't understand that. How do they get their own costs if it is prospective?

THE WITNESS: A hospital's 1976 rate is

based on reported 1974 costs. So when you look at 1974 costs and you find a hospital whose costs per unit of services is 95 per cent of the average, that hospital is unaffected by ceilings. They actually get their reported costs printed forward, which, incidentally, is the 15 hospitals that we have.

THE COURT: I understand.

Mr. Imberman, go ahead.

BY MR. IMBERMAN:

Q Let me ask you one other question on studies that you have made in connection with the promulgation of the 1976 rates.

Did you make any studies from which you were able to determine that any of the voluntary hospitals which are involved in this case, which is all 275, were rendering services in an inefficient manner?

THE COURT: I think the word "inefficient" is too arguable.

MR. IMBERMAN: I am using it because it's a word of art, particularly in the state statute, which talks about hospitals being reimbursed for the reasonable cost of the efficient production of their services, and I am sure Mr. McCann is familiar with that phraseology.

THE COURT: If you want to ask him did he make any studies in relation to the question of whether hospitals were providing services efficiently or not, you may do that, so we don't have worries about whether they were efficient or inefficient.

A May I answer you this way: When you take hospitals and put them in a group and you have a good group of comparable hospitals and some hospitals are 20 per cent higher than other hospitals, certainly the question of efficiency has to be raised.

Now, if you call that a study, the answer to your question is yes.

Q I am asking whether you made any specific studie from which you determined that any voluntary hospital in the state was rendering medical services, hospital services, in an inefficient manner.

THE COURT: Only to that extent.

A Yes, to that extent, sir.

Q The only extent that you are saying is that if you compared a particular hospital with those in its group, if its average cost, its per-diem costs, were higher than the average of the group you would say that is inefficient?

A No, I would say something different.

Q What would you say?

A I would say that that hospital's cost patterns certainly raise questions. The rated average ceiling puts a penalty on that hospital. The hospital's position is now to come in and establish that it is providing services efficiently.

Q Mr. McCann, what I am trying to find out from you is at what point, if any, do you consider that a hospital is inefficient or rendering services inefficiently when its cost varies to any degree from the average?

A In 1976 the point is the average. There is no one particular point to identify reasonable cost.

Q I'm sorry.

A Reasonable costs can be defined in a variety of ways, depending on the definer, and we defined it since 1976 by placing a ceiling on the average. Anything above the average we have determined should not be reimbursable --

THE COURT: Well, the problem, of course, which is represented by this lawsuit is that the state is not free to refine reasonable cost in any way that is inconsistent with the federal statute.

It may be held that your definition is correct, but while it is philosophically true to say that reasonable cost may be defined 100 different ways in a legal proceeding, it has to be defined in accordance with whatever the law says it is.

THE WITNESS: If I might --

Q Please limit yourself to answering my questions.

A Yes, sir.

Q You are saying, in effect, that if you take a group of hospitals and you average their costs, that any hospital which has a cost above the average, and there must be some, is rendering services ineffiicewntly and has unreasonable costs?

THE COURT: No, I don't think so, Mr. Imberman. There is no reason to put words in his mouth. I understand entirely what he said. You can disagree with it, but what he said is, "We are taking the position this year that the definition of reasonable costs is average costs. Anybody who is above that as far as we are concerned has to show us why they are above that and give us a reason why."

THE WITNESS: Yes, exactly.

MR. IMBERMAN: Oh, no, your Honor.

BY MR. IMBERMAN:

Q You immediately penalize a hospital, don't you, under the 100 per cent average cost?

A Yes.

Q If it is above the average?

A Y es.

THE COURT: Yes.

Q And the hospital gets less. You promulgate a rate which is less than its cost?

A Yes.

Q Without looking into whether or not the reason for its cost is perfectly justified?

THE COURT: That's why I talked in terms of burden of proof.

We are really talking about, and it is an important question, who is supposed to do what to establish the reasonable costs. And as I understand the state's present analysis, it says it will go so far and accept that as being reasonable. Beyond that you have got to prove to us that it is reasonable.

THE WITNESS: That's correct.

MR. IMBERMAN: Your Honor, I don't think --

THE COURT: Let Mr. Imberman finish and

then, Mr. Fine, I will hear from you.

I don't mean wait until he finishes the questioning.

MR. FINE: I wanted to say something about the questions, the nature of the questions. He is in effect saying that because the hospital is penalized, it is necessarily a finding that the hospital is inefficient. I don't think that Mr. --

THE COURT: Let's leave it to him to argue whether it is. The purpose of the questioning is that he is trying to bring out information, not to raise arguments.

BY MR. IMBERMAN:

Q You would agree, Mr. McCann, would you not, that a hospital may have a cost which is above the average and still be operating at 100 per cent efficiency?

A Yes, I would.

Q And that the reason it is above the average is something that could be completely beyond its control?

A YES.

Q Now, Mr. McCann, is it not true that the reason that the department reduced the limitation on routine costs from 110 per cent of the average, which it always was, to 100 per cent of the average was because you were told that the state had to cut its outgo of Medicaid moneys?

THE COURT: I think that's an interesting history but the more I think about it, the less legal relevance it seems to have. Because if the formula is okay, it doesn't make any difference what the motivation is. And this is in a sense a quasilegislative Act.

MR. IMBERMAN: If your Honor please, it seems to me that if both the Health, Education and Welfare Department and the courts have held that a freeze is illegal as far as the Medicaid status is concerned, then it seems to me when you, in effect, reduce the rate to a freeze rate or below by imposing artificially an average to create that, you are doing the same thing, and motivation is important.

THE COURT: I'll agree with you. First of all, I don't think you need to ask the witness the question because I don't think there is any dispute about that. But to go on to the argument you just made, I think it may be evidence that the rate ultimately reached does not reflect reasonable costs but they are not prevented by the Medicaid statute from getting together and saying, "Listen, we have got to cut the costs," if they can do it legally.

MR. IMBERMAN: I thought it was relevant because the argument that seems to be presented is we want to get hospitals, after years of 110 per cent and now the study says 100 per cent is better, when in fact it seems to me the 100 per cent average was created only because there was a "U" case, we have got to cut costs and this is one way of doing it.

THE COURT: As I say, I think that is perfectly reasonable for a "U" case to be made because of the fact of the previous formula being too generous. And I am not saying that it was, but it theoretically could be.

I would like to explore further with the witness the question of appeal. Because the analysis that I have been making that you say is correct as to what the state's position is assumesd that if on appeal a hospital shows you that its costs above average are reasonabla, an adjustment will be made to see to it that it gets reasonable cost, is that correct?

Let's say Mt. Sinai shows you that their reasonable costs are 5 per cent above 100 per cent. What happens then?

THE WITNESS: Yes, sir. They would. Just exactly the way you put it. Their costs are over the average and they come in and are able to demonstrate the reasons why the costs are over the average, are justifiable, they would, and that would be the basis for the appeal.

MR. IMBERMAN: If your Honor please, it seems to me that a formula which requires 50 per cent of the hospitals to take appeals --

THE COURT: Well, that's for legal argument.

Are there any further questions?

MR. IMBERMAN: Yes.

BY MR. IMBERMAN:

Q Mr. McCann, would you look at your affidavit, at paragraph 24, and I would like to follow up on something the judge asked in there.

Have you got it?

A Yes.

Q When you said the hospitals have generally failed to respond to the state's cost control efforts, the state fixed the Blue Cross rates, am I right?

A Approves them, yes.

Q And the hospitals have to live within that sum of money as far as their costs are concerned, isn't that so?

A If that's all the money they have, certainly, all that is available to them, they would have to live within the anticipated service revenues.

Q And the same as the Medicaid, they are established by the state and that's what the hospitals get?

A Yes.

Q And that represents in most of the hospitals over 50 per cent of what their income is, isn't that correct?

A Yes.

THE COURT: The total of the two items?

THE WITNESS: Yes.

Q You said in that same paragraph that in New York City the average annual rate of increase during the period 1970 to '74 wasapproximately 13-1/2 per cent, is that correct?

A Yes, sir.

Q Now, what you are talking about its the average rate of increase in per-diem costs, correct?

A Yes.

Q How much of that rate was established by your trend factors in each one of those years?

A How much of that rate?

Q Of that increase. Sorry. The percentage increase.

A This is an increase in cost.

Q I understand that.

A And yours is in rate. You mean how much did our rates go up during that period?

Q No. You had a trend factor in each year, am I right?

A That's correct.

Q In which you anticipated that as a result of inflation the hospitals' costs would go up in the coming year and you incorporated that trend factor to give them more money because of inflation, am I right?

A That's correct.

Q What I am asking you, sir, is in this average of 13-1/2 per cent how much of that increase is inflation responsible for?

THE COURT: Just approximately.

A I am not sure whether I have any papers that I can give you on that.

Q Let me ask you this: The trend factors for each year would have been your estimate at the beginning of the year of how much inflation was going to push up the hospitals' costs, isn't that so?

A That's correct.

Q And if the trend factor for those five years that you are talking about was 10 per cent, then the actual increase, the adjusted increase, would only be 3-1/2 per cent, isn't that so?

A Over inflation as computed by us, that's correct.

Q In addition to that, there would be increases in hospital costs as a result of new programs that the Health Department had approved, isn't that so?

A That's correct.

Q And there would also be increases in the hospitals' costs as a result of new technologies that had come along that the hospitals were using, isn't that so?

A Could be.

THE COURT: I am aware of certain things.

MR. IMBERMAN: Open-heart surgery is a great advance but it is horribly expensive, your Honor. It is as simple as that.

Q Are you familiar with Professor Dowling's study that he made for HEW?

A Yes.

Q Have you read his study?

A No. His study has not been released as yet.

Q Have you read the draft?

A Parts of it.

Q Are you familiar with the fact that he compared for HEW the costs of hospitals in downstate New York since 1970 with the costs of hospitals in three other large cities?

A Yes, I am.

Q Which were the cities? Do you know?

THE COURT: Let's not play a guessing game.

A Chicago, Philadelphia and Cleveland, I believe.

Q And that was a study to find out what the result of prospective reimbursement was, isn't that correct?

A Yes.

Q And did Professor Dowling in that study come to the conclusion that prospective reimbursement in the downstate New York area had decreased very sharply the reate of increase in hospital costs?

A   I am not sure about the word "sharply." He came to the conclusion that there was a decrease.

THE COURT: You mean there was a deceleration in the rate of increase?

THE WITNESS: In the rate of increase, as compared to the three control cities.

Q   As a matter of fact, he said the rate of increase in New York, once you adjusted for inflation and outpatient costs, was only about 1.9 per cent a year, isn't that so?

THE COURT: If he did, he did.   Why does the witness --

A   1.9 per cent a year?

Q   Yes, average.

A   Increase in costs.

THE COURT: I will cut off the question on that point.   If you want to put the study in evidence, that's all right, but don't test Mr. McCann on it.

Q   I would like you to look at your affidavit at paragraph 21, page 8, which I want to ask you a question about.

A   Yes.

Q You have a subparagraph No. 1 there, and in that paragraph you are talking about how prospective rate formulas work. And you say that the costs reported by hospitals must be challenged to eliminate on a broad base those costs not related to patient care and unjustified cost variances among hospitals of approximately the same size.

Do you see that?

A I am not sure what page you are on.

Q Page 8, paragraph 21. It is your affidavit.

A Yes, I have it.

Q Read paragraph 21, and particularly subparagraph 1.

(Pause.)

Q What you are saying is that in the formula what you have to do is to eliminate unjustified cost variances among hospitals of the same size, right?

A Yes.

Q And I take it then that justified cost variances are permissible?

THE COURT: There is no dispute about that.

A Yes.

Q Then would you mind telling me how you can have a permissible justified cost variance when you have 100 per cent average limitation?

THE COURT: I feel like we are bogging down here, Mr. Imberman, and most of the questions are argumentative rather than fact-finding.

I could answer that question myself at least two ways. First of all, you have cost variance below 100 per cent and, secondly, we have discussed the question of the appeal procedure, which I assume will allow some variances above. Is that correct?

THE WITNESS: That's correct.

Q Then please take that Exhibit E, the one that you produced, the chart. You have the caption there "Penalty as a per cent of inpatient cost," and what year are those costs?

A '74.

Q '74?

A That's the cost base for the penalty.

Q But we are talking about a 1976 rate, aren't we?

A Yes, we are.

Q Now, when you say, for example, that Mt. Sinai has been penalized 2.7 per cent, you say that is the amount of its penalty as a percentage of its costs?

A That's '74 costs.

Q '74 costs? But Mt. Sinai Hospital has filed an affidavit by Dr. Pomrinse which indicates that it's 1976 costs are $270 a day and the rate that you promulgated for 1976 for that hospital is $240 a day.

Now, that is susbstantially more than 2.7 per cent, isn't it?

THE COURT: Yes.

A Just that straight comparison.

THE COURT: I'll take judicial notice.

MR. IMBERMAN: The point I am trying to make is this is a very deceptive document.

THE COURT: I understand the point. The 20 million and the 2 million or the 19 million and the 2 million is more like 9 per cent the way Dr. Pomrinse looks at it.

MR. IMBERMAN: I think they have been penalized at least 10 per cent of their 1976 costs.

THE COURT: Right.

THE WITNESS: No question, so I can't comment.

Q Do you know how many hospitals in total ✓re ree penalized, to use your language, by the new ceilings, the 100 per cent ceilings?

A I do not have that information with me. I have just looked at the voluntary hospitals. It'S available.

Q Let me ask you one other question.

Did the Department of Health make any study to determine that 10 per cent of the costs of the salaries of interns and residents represented educational activities? Have you got any study?

A The department relied generally on studies that have been made but I could make them available, if you wish.

THE COURT: Are you talking about the NLRB?

THE WITNESS: Yes, and the National Institute of Science.

Q Do you know how many hospitals the NLRB study was based on?

A No.

Q Did you know that it was based on a study of one hospital?

A No.

Q In your opinion, would a study made on the basis of one hospital be valid enough for the Department of Health of the State of New York to act upon?

A I can't comment. Are we talking concept, philosophy or dollars?

Q I am talking what you, William McCann, would do. Would you accept the study of one hospital in making the changes based on millions of dollars?

A Depends on the area.

Q Yale, New Haven.

A It depends on the area that we were talking about. I find it hard -- I would think if you took the study of one hospital and you found the cost 40 per cent under the average of the cost of the group, that would be improper. In another situation, you look at one hospital and you find that you are looking merely to find the philosophy and concepts, it might be appropriate.

Generally, no.

Q Do you think it is statistically valid to use one hospital?

A I would say generally, no.

Q Has the appeal procedure been approved, the procedure you are talking about?

A By whom, sir?

Q By HEW.

A No.

THE COURT: Is it at the same level of approval by the state and submission to the federal government for approval as the rest of the amendments?

THE WITNESS: Yes.

MR. IMBERMAN: I don't think this is filed yet.

THE COURT: That's what I am trying to find out.

Let's be very clear about it, Mr. McCann. Is the appeal procedure in exactly the same status as the rest of the amendments? Is it an integrated plan or -- I don't remember hearing about the appeal procedure in the early part of this case and I want to be sure that I understand it.

THE WITNESS: Because of the relationship between the federal government and the state, the single state agency, all I can really testify to is that this has been submitted, the single state agency, for submission to HEW.

THE COURT: And in the same fashion and approximately the same time or as part of the material submitted with regard to the three regulations?

THE WITNESS: This was a later submission.

THE COURT: How much later, approximately?

Mr. Fine, do you have any information as to the present status of the proposed appeal procedure?

MR. FINE: Your Honor, I know that it was adopted very recently by the state.

THE COURT: Do you know if it's been submitted to HEW for approval?

MR. FINE: I'll have to find out.

THE COURT: Do you know, Mr. Budoff?

MR. BUDOFF: We have not received a submittal on a new appeals procedure.

MR. FINE: I gather it has not been submitted to HEW.

THE COURT: I will assume it has not unless I hear to the contrary.

MR. IMBERMAN: I have no more questions, if your Honor please.

THE COURT: Very good.

MR. IMBERMAN: I have some other things I would like to take up, however.

THE COURT: Yes.

Do counsel have any further questions of the witness?

MR. FINE: I just want to clarify Exhibit E.

REDIRECT EXAMINATION

BY MR. FINE:

Q Mr. McCann, will you explain, please, exactly what you mean by penalty as a percentage of inpatient costs referring specifically to the years involved?

I understand what you mean by penalty. That was the penalty imposed basically on the 1976 rate for failing to reach the average. But will you explain to the court exactly what that heading means in Exhibit E?

A Yes. All this exhibit does is it shows a relationship between the amount of dollars that are eliminated from reimbursement considerations and the total inpatient dollars during that year. The year 1974. In 1974 what this exhibit says is that Mt. Sinai Hospital had costs in excess of the weighted average ceilings that we placed on ancillary and routine costs that were equal to 2.7 per cent of the total inpatient cost in that year, 1974.

THE COURT: 2.7 of its own --

THE WITNESS: Of the total inpatient costs at the facility, not related to Medicaid but total inpatient cost.

A Now, this cannot be comfortably related to an increase or a decrease in the rate because a rate can change because of the utilization in the facility, the number of patient-days, so you can't make a direct comparison, and all this does is show the relationship between the size of the disallowed costs resulting from the penalty and the total inpatient costs during that same period of time, which in this case is 1974.

Q I understand that.

Now, will you tie what you just said into the caption at the top of the page?

MR. IMBERMAN: He said it.

Q How does that penalty resulting from the 1974 rate affect the '76 rate?

A In determining the 1976 rate we start off with a basis of allowable costs. Those costs that are in excess of the average, weighted averages that we are using, are included from allowable costs and trended to '76.

MR. FINE: I have no further questions.

THE COURT: I would like to see the attorneys in the robing room, but I think this is all of the hearing for today and I hope at all.

Thank you very much.

(Witness excused.)

(In the robing room.)

MR. IMBERMAN: I would like to renew the application which Imade some time ago in chambers for a temporary restraining order in this case primarily because the time is going along. We are almost to August 1st. All of the new rates promulgated by the department are being fed into computers all over the state. At least one hospital that I know of, the Genesee Hospital, one of the main plaintiffs in the case, has had its application for Medicaid payments by Erie County returned to it with a memorandum on it, and I am going to offer it in evidence -- I gave Mr. Fine a copy -- which in effect said that the controller of Erie County had received word of the new rates which were retroactive to January 1st and he was sending these bills back to Genesee Hospital saying, "Please submit them at different rates."

So that I am sure that this will be happening all over the state, and once these things get into the

jba38

computers the hospitals are going to be very severely penalized because they will be cut back and this appeal procedure which Mr. McCann talks about is way down the road, and I sort of question a formula which says half the hospitasl in the state can apply for appeals if they think they don't have enough money.

We are dealing here with I think a flatly illegal situation. Everybody concedes there has been no HEW approval. I don't think the hospitals have to get involved in a dispute between Mr. Fine and Mr. O'Connor as to whether some sort of pattern was established between them.

The fact of the matter is here there has been no approval, I don't care what happened before, and the hospitals are being penalized by it, and the cases and tthe law are clear that regulations which do not have HEW approval which relate to the payment of inpatient costs are invalid, and if they are I think your Honor is obligated to say so and let the state go back to the approved plan and pay the hospitals on that basis, at least for the time being, until your Honor gets there. There is ample ground for a temporary restraining order.

Now, the alternative, of course, is what your Honor suggests, and that is, as far as I am concerned, there is no further evidence that has to go in and I would be perfectly willing for your Honor to consider this as a hearing on the merits.

I don't think there is anything else.

MR.FINE: Your Honor, you have been very patient and I am not going to repeat the arguments respecting HEW approval.

It is perfectly true that the new rates are being implemented and it is perfectly true also that the impact on the hospitals is not that enormous as to warrant a temporary injunction.

We are talking, even in the case of the largest hospital, like the Mt. Sinai Hospital, of a comparatively minimal amount, considering the scope and size of the hospital operation. There is no irreparable damage being done them. The state fiscal crisis may be a matter which I need not estend upon, you are perfectly well aware of it.

The state has started to implement the new rates and I am sure will continue to do so.

If your Honor should grant a temporary injunction it would mean that these 83 hospitals would now be paid at their 1975 rates, which would mean an outlay of money by the state and which would also mean that eventually if HEW approves the new regulation these hospitals will be compelled to refund the overpayment.

I submit to your Honor, and I think I need not extend on it, the considerations, the basic considerations, it seems to me, are that the hospitals in general, as Mr. McCann pointed out, very few of them are affected by the new regulation at all and --

THE COURT: There are two or three layers. One is if the case is handed to me as a matter for preliminary injunction as distinct from a TRO or as distinct from determination on its merits, then the question of irreparability of harm which you are raising is a significant one.

If, as sooner or later has to be the case, the matter is presented to me on the merits and if you take the same position that Mr. Imberman does, that as far as you are concerned the record, the evidentiary record, is complete here and it should be decided on the merits, then it seems the questions of irreparable harm are less significant than the questions of validity and invalidity, more so.

Let me ask first whether you agree with Mr. Imberman, whether from your point of view also the evidentiary record is complete and you would be satisfied to have the court --

MR. IMBERMAN: I am talking about the first cause of action relating to the inpatients.

THE COURT: All right. That's all we have been talking about.

MR. FINE: Your Honor, there is one other reason that is in my mind and I would be less than fair if I did not mention it to you.

I am hopeful that under the pressure of this very litigation both the State Department of Social Services and HEW will hasten their deliberations and act to get the approval that at this present moment is lacking.

THE COURT: I am sure the plaintiffs are too

What result would that have?

MR. FINE: It seems to me that that might mean that a determination on the merits, which I would frankly like to delay, to treat this as a plenary trial might give me the advantage, and I am speaking now in adversary terms, of being able to come to the court

jba42

and say, your Honor, that problem is now disposed of, HEW has approved the regulations retroactively, but from the point of view of the temporary injunctions -- and I would like to keep this case at that layer --

THE COURT: Mr. Fine, I think the matter is too serious for us to worry about who makes what particular advantage, and I am- sure you are not personally anxious to take take advantage of the situation.

Mr. Imberman has said that he has presented all the testimony, or maybe there will be another exhibit or two, that he intends to prove or to submit, rather, in relation to the first cause of action.

So what I want to ask you is have you submitted all the testimony you want to?

MR. FINE: Yes.

THE COURT: Then I think it is my obligation to regard this matter as having been tried as to the first of action and to determine it as to the merits. In that regard, at least at the moment, my inclination is not to grant a temporary restraining order.

I at the very least want to review the arguments presented by Mr. Fine as to whether or not the relations are inconsistent and so forth. I

jba43

heard the argument today but I have not studied the regulations and I am certainly not going to grant a temporary restraining order at this moment.

It is fair to say, however, that I think that the argument in that regard favors the plaintiffs and I will give due consideration to what ought to be done under those circumstances.

Now, in relation to the question of relief which even in the determination on the merits, insofar as you asked for an injunction, raises the question of the court's discretion, I am not saying I won't grant an injunction if I find you prevail, but at least that remains a question of discretion theoretically.

Can I have a representation, or do I have a representation from the state that if the court finds that the state procedures are invalid and if the state is nevertheless not enjoined but later on is found to owe money to the hospitals, that it will not raise the Eleventh Amendment as a defense to any suit by the hospitals to secure that money?

MR. FINE: I think I can make that statement, your Honor.

THE COURT: All right. Thank you.

jba44

MR. IMBERMAN: There is only one other issue that might be involved, your Honor, which I think in fairness I should raise. We do have a class action. There has been no class certification.

THE COURT: Do you have any objection to a class certification?

MR. FINE: None at all.

THE COURT: All right. That is made.

There is one other point. Mr. Fine has moved to dismiss.

You haven't answered that.

MR. IMBERMAN: I will have a brief in your Honor's hands hopefully by the end of the day tomorrow and I have another affidavit, a reply affidavit to Mr. McCann's, which I will serve right now and give it to your clerk.

MR. O'CONNOR: With regard to the merits, we are about -- and I mean either today or tomorrow -- we are about to file a motion stating that with regard to the relief as to the federal defendant, that it is a discretionary decision, that the Secretary is in the process of making that discretionary decision, and therefore the relief should not be granted.

This is made as a motion to dismiss for lack of subject matter jurisdiction and for failure to state a claim upon which relief may be granted. The memorandum is being prepared and final touches are being made and will be served today or tomorrow.

THE COURT: All right. Thank you.

- -

WITNESS INDEX

Name	Direct	Cross	Redirect	Recross
Seymour Budoff	116			
William F. McCann	135	158		

EXHIBIT INDEX

State Exhibit	Identification	In Evidence
B		96
Federal Exhibit		
E	120	122

Toia opinion

mdmch

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

--x

HOSPITAL ASSOCIATION OF NEW YORK STATE INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., and which are reimbursed for Medicaid services rendered to hospital patients,

Plaintiffs,

v.

76 Civ. 2027

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U.S. Department of Health, Education and Welfare,

Defendants.

--x

Before: HON. MORRIS E. LASKER,

District Judge.

New York, New York
July 29, 1976 - 3:45 p.m.

mdmch

APPEARANCES:

PROSKAUER, ROSE, GOETZ & MENDELSOHN, Esqs.,
Attorneys for Plaintiffs,
By: JACOB IMBERMAN, Esq., of Counsel.

LOUIS J. LEFKOWITZ, Esq.,
Attorney General of the State of New York,
By: JESSE FINE, Esq.,
Assistant Attorney General.

ROBERT B. FISKE, JR., Esq.,
United States Attorney for the Southern District of New York,
By: JOHN M. O'CONNOR, Esq.,
Assistant United States Attorney.

-o0o-

(In chambers)

THE COURT: Since yesterday's session I have studied the statute and the regulations with particular reference to whether I find merit in the argument of the State that the statute, by which I refer to 42 USC, Section 1396a(a)(13)(D) and its subparts, is consistent with the applicable regulations in 45 CFR, and whether two of those regulations, namely, 45 CFR 250 and 45 CFR 205 are inconsistent with each other.

I have concluded that the inconsistencies which the State alleges are not inconsistencies, and will explain my reasons in due course in this discussion.

I have indicated that under the circumstances I feel obliged to grant injunctive relief which will have the effect of seeing to it that the plan does not go into effect without the approval required, as I see it, by the statute and the regulations, but to stay such an injunction for ten days to permit the State to appeal.

We are now discussing whether it is necessary, even under the Court's view of the matter, to enjoin the entire operation of the State amendments, or whether it would be appropriate to limit the injunctive relief to those hospitals which would receive less money under the State amendments than they did in 1975, or, more

mdmch

accurately stated, receive money at a lower rate than they did in 1975.

Mr. Fine argues that the more limited relief should be granted, and I will be glad to let him make a statement for the record on that point.

MR. FINE: The basis for my position is this: that the request of the petitioners seems to be limited, as far as I can tell from the order to show cause seeking relief, for a preliminary injunction --

THE COURT: Would you tell us where you are reading from?

MR. FINE: Page 2 of the order to show cause signed by your Honor on July 16.

It says that a preliminary injunction to issue enjoining reimbursement at less than the 1975 Medicaid rate of any plaintiff or member of a class.

I submit this is the relief they sought. This is the thrust of our defense as to why -- we allege 84 -- I am not particularly concerned with whether there are in fact 83 or 91 hospitals -- Mr. Imberman claims it's 91 -- hospitals are receiving less than their 1975 rate.

I should recall to your Honor originally when this action started the plaintiffs' complaint was all the hospitals were receiving 1975 rates. Quite obviously now a majority of the hospitals are not receiving 1975 rates; they are receiving greater than 1975 rates.

The action was changed completely in its scope when on July 1 the State announced the 1976 rates with respect to all but either 83 or 91, and the number is not, I think, at this point of time of consequence.

The State announced new rates which, in most cases, gave a higher increase to hospitals, or a higher rate of reimbursement.

I submit, therefore, that the plaintiffs' only request for relief is related to those hospitals getting less than their 1975 rates of reimbursement. That number is 83 or 91, and I think that your Honor's injunction against the State should be limited to those 83 or 91.

MR. IMBERMAN: If your Honor please, it seems to me clear that your Honor has decided that the law is plain with regard to the requirement that there be pre-implementation approval by the Secretary of HEW, and without that approval these regulations are not valid. That is the thrust of the entire case.

The second point that we argued was that the regulations also are invalid because they don't produce reasonable costs.

I gather for the moment your Honor is only focusing on the first issue.

THE COURT: I am not only focusing on it, but I want to make it plain on the record that I have reached no conclusions whatever as to whether the amendments are providing a reasonable cost.

MR. IMBERMAN: Once your Honor has decided that the regulations are invalid, then it seems to me that the State must be prohibited from putting them into operation, whether it is 83 or 85 or 90 or 100.

What we are talking about is regulations which are invalid, and your Honor is saying the State may not inforce them.

It seems to me that that is the crux of the matter, that these regulations are invlaid, and the State may not enforce them, and the State must then proceed on the basis of what the State plan was as approved by HEW before these regulations were promulgated as of July 1.

MR. FINE: Yes, but even if that is so it does not follow that any of the hospitals, other than those receiving less than their 1975 rates, have yet demonstrated irreparable damage to them.

MR. IMBERMAN: We have demonstrated irreparable damage by the affidavits and the proof of Mr. Ingram.

MR. FINE: But only with respect to those hospitals receiving less than 1975 rates.

MR. IMBERMAN: Not necessarily, because a hospital can have irreparable damage if it receives the same rate in 1976 that it did in 1975, when inflation has proceeded at 7 or 8 percent.

THE COURT: Mr. O'Connor, do you have anything to add?

MR. O'CONNOR: No.

THE COURT: Gentlemen, I am prepared to rule on that issue, which I think is probably the only issue that needs disposition before I make findings of fact and conclusions of law.

MR. FINE: May I make one further statement, your Honor?

If your Honor relegates the State to computing the rates under the preexisting formula, and assuming HEW does not within the next week, ten days, or two weeks, approve these regulations, the State will be faced with the practical problem of computing rates under the preexisting formula.

How long this will take, I cannot say. There are not only the voluntary hospitals, there are the proprietary hospitals, and it will take some time.

We will proceed to take an appeal to the Circuit Court, but I want to say, as a practical matter, the State will have the problem of recomputing the rates for 1976 ab initio.

MR. IMBERMAN: I have asked my expert that very question, and my people have seen the individual calculations sheets of the Department of Health for each hospital, and I have been told, if you just take out the ceiling limitations which flow from the two critical rates, the 10 percent for interns and the 100 percent average, a recomputation can be done in about ten minutes for each hospital.

THE COURT: I have no way of knowing which view is correct about that.

I can only say, Mr. Fine, if there is a problem which is presented, I will not expect the State to do anything more than its best done in good faith.

If I should be affirmed by the Court of Appeals and the matter is sent back to me, I will, of course, entertain any application the State puts before me for modification of the injunction so that the realities

mdmch

of life can be taken into account.

I am making the following statement on the record, ladies and gentlemen, because of the importance of this case, the fact that I am not in a position to draft a written opinion since I will be away from the court commencing the end of this week for a short vacation, and I don't want to let that interfere with the disposition of what I consider to be a matter of considerable public importance.

I should say on the record, however, out of fairness to all of you and for the benefit of the Court of Appeals judges, if they read the transcript of this meeting, that voluminous papers have by now been filed in this case and approximately a full day of hearings has been held, and I think I do have a grasp of the facts sufficient to take the action I propose to take today.

In addition to that, the subject which I am acting on is really a pure question of law, and perhaps it could have been acted on even earlier except that it took time to crystallize that issue and for the Court to familiarize itself with relation to that issue to the subject at large.

Plaintiffs moved for a preliminary injunction and for permanent relief to the same effect to enjoin the

State from reimbursing any plaintiff or member of the class for services rendered on or after January 1, 1976, at an in-patient hospital Medicaid rate which is less than its 1975 rate, and although the order to show cause is cast in those somewhat limited terms, the complaint itself asks for broader relief, which I refer to what I consider the relevant paragraphs of the complaint, in regard to the question of whether or not the proposed amendments to the State's Medicaid plan, the actual amendments, are yet valid.

In particular, I refer to paragraph 4, which states the 1976 in-patient rates were calculated pursuant to several new regulations which have not been approved by the Secretary of the United States Department of Health, Education and Welfare as part of the plan government the New York State Medicaid program. Such approval is required under the Medicaid Act, it is alleged.

The next paragraph of the complaint which I consider to be relevant to this issue is paragraph 50, page 15, which states the calculation and payment of the class' 1976 Medicaid in-patient hospital reimbursement rates violates the supremacy clause of the United States Constitution, Article 6, because it was done in accordance with regulations which have the effect of State law, and which are in conflict with the laws of the United States on the same subject, the conflict here being with 42 USC Section 1396a(a)(13)(d) and with the regulations which implement that statute.

Finally, the complaint says on this issue, in request for relief sub-clause (c) at the bottom of page 20: Wherefor plaintiffs pray that this Court issue an injunction ordering the State defendants and their successors, et cetera, to comply with all federal laws and regulations of the United States Department of Health, Education and Welfare applicable to the New York Medicaid program, including reimbursement on the basis of reasonable costs, so long as the State of New York continues to participate in the federal Medicaid program.

I may comment that it seems to me that the prayer for relief in sub-paragraph (c) is sufficiently broad to grant an injunction against the operation of the amendments not limited to those hospitals which necessarily are receiving less money today than they were last year.

For the purposes of simplicity, I will refer to this subject matter hereafter as the first cause of action.

The State opposes on two grounds. It has moved to dismiss the complaint, and it has argued with regard to the federal statute and federal regulations that one of the regulations to be discussed hereafter is inconsistent with the statute and inconsistent with another of the regulations.

I will deal first with the State's motion to dismiss.

By Public Law 94-182, Section 111a, the United States Congress, which amended Title XIX of the Social Security Act, 42 USC, Section 1396, Congress required any state which received federal funds under the Medicaid plans to waive its immunity to suit under the Eleventh Amendment to the Constitution of the United States.

New York State did waive its immunity in writing, but by letter, which indicated that it protested, in effect, the requirement of waiving. There is no doubt in my mind that the State saved its right to challenge the validity of the waiver provisions of Public Law 94-182.

The State argues that it signed the waiver under what it describes as financial duress. That the

State was certainly in a position of financial difficulty there is no doubt, and I take judicial notice of that fact.

That the State did not willingly give up its Eleventh Amendment rights, if that word be used as a layman would use it, I will agree.

But that the State did not waive its rights legally, or that it was subject to a form of duress which would render its waiver ineffective, I do not agree and I do not find.

A principal authority which the State relied on to support its position that the waiver was not valid in law because not freely made was the concurring opinion of Mr. Justice Marshall in Employees v. Missouri Public Health Department, 411 U.S. 279.

In that case, employees of the State of Missouri brought suit for overtime pay claimed to be due them under the Fair Labor Standards Act. The District Court dismissed the case as being an unconsented action against the State, barred therefore by the Eleventh Amendment. The Court of Appeals affirmed. The Supreme Court held six to three that the Eleventh Amendment did apply because the Court couldn't discern any intent on Congress' part to deprive the State of its Eleventh

Amendment immunity.

Justice Marshall concurred in the decision but wrote a concurrence, as I see it, because he felt that the decision should have been based on the theory that the State did not waive its immunity and had not consented to federal suit. As he put it, at page 296, "To suggest that the State had the choice of either ceasing operation of these vital public services or 'consenting' to federal suit suffices, I believe, to demonstrate that the State had no true choice at all and thereby that the State did not voluntarily consent to the exercise of federal jurisdiction in this case."

Applying Justice Marshall's remarks to the instant case, the State argues that since it had already for some years undertaken the obligations of the operation of a Medicaid plan, it was totally unrealistic to believe that it could discontinue the plan, and, therefore, it was under the kind of duress at the time that the waiver provision enacted by Congress occurred, and it did not waive its Eleventh Amendment immunity with any true consent, but under the gun of the deprivation of federal support.

While I agree with the State that its analysis is consistent with Justice Marshall's position, I do not believe that Justice Marshall's position is the law, or at least the law as set forth in Employees v. Missouri Public Health Department.

To the contrary, Justice Douglas' opinion for the majority there makes it clear, at page 285, that the rationale of the case was based on the Court's inability to find that Congress had intended to "make it possible for a citizen of that state" -- that is, the employer's state in the case of Missouri Public Health Department -- "or another state to sue the state in the federal courts."

It seems to me that if, as Justice Douglas and the majority held, the determinative factor as to whether or not the State could be sued depended on whether Congress intended that they could be sued, it necessarily follows that the Court holds that Congress has the right to provide that a State may be sued under the circumstances both of the Missouri Public Health case and the case at hand.

There is no dispute that in the case at hand Congress has specifically provided that in order to secure the benefits of federal assistance the State must consent to be sued, and I think that disposes of the issue.

I come now to the discussion of whether the plaintiffs are correct that the amendments to the plan may not be put into effect without the prior approval of the federal Department of Health, Education and Welfare.

The crux of the State's disagreement with that proposition is to be found at pages 4 through 7 of its memorandum of law in opposition to application for a preliminary injunction, and is crystallized at pages 5 and 6.

As set forth on page 6, the State argues, "The thrust of our argument is this: that 45 CFR 250.39(a)(requiring approval in advance of implementation, is inconsistent with the statute 42 USC, Section 1396a(a)(13)(D), which simply requires approval, and with the other regulations cited above."

The other regulations cited above is found at page 5 of the brief answer, 45 CFR 205.5(b).

That regulation speaks in terms of an "approvable" amendment, and it is the argument of the State that the two regulations are inconsistent with each other and with the statute.

For the following reasons I disagree with the State's analysis:

First, the statute provides as follows:

"(a) A state plan for medical assistant must ...

"(13) provide ...

"(D) for payment of the reasonable cost of in-patient hospital services provided under the plan, as determined in accordance with methods and standards consistent with Section 1320(a)(1) of this Title, which shall be developed by the state and reviewed and approved by the Secretary."

I find no inconsistency whatsoever between the phrase "which shall be developed by the state and reviewed and approved by the Secretary," as set forth in the statute, and the phrase in CFR 250.30(a)(2), the language of which reads:

"(a) A state plan for medical assistance under Title XIX of the Social Security Act must ...

"(2) provide for payment of the reasonable cost of in-patient hospital services in accordance with methods and standards which shall be developed by the state and approved in advance of implementation by the Regional Commissioner ...."

I think it normal to construe the word "approved" to mean approval in advance, particularly in subjects as complex as this, and particularly where the public welfare is involved, and particularly where the federal government, which is the approving agent, will be paying large sums of money in connection with the subject matter which is to be approved.

As to the alleged inconsistency between the material discussed so far and the remaining regulation referred to by the State, specifically CFR Section 205.5, which covers amendments to plans, and is applicable in the circumstances, I find no inconsistency for the following reasons:

The relevant language of Section 205.5 reads:

"(b) Federal financial participation. Except where otherwise provided, federal financial participation is available in the additional expenditures resulting from an amended provision of the state plan as of the first day of the calendar quarter in which an approvable amendment is submitted, or the date on which the amended provision becomes effect in the state, whichever is later."

The language of Subsection (b) does not seem to me to be inconsistent with the other regulation referred to above or with the statute because:

One, the subject matter, sa the title indicates, does not deal with when the amendments become effective, but rather with when the federal financial participation may be received.

Second, and perhaps more important, the clause starts with the words "except where otherwise provided," and it seems to me that language clearly includes the exception of the specific provisions of CFR 250.30 which have been discussed above.

Moreover, it appears to be the Department of HEW's construction of the statute and the regulations that prior approval by HEW is necessary before amendments to a state plan may become effective. I refer to the affidavit of Seymour L. Budoff, an authorized official of the department, filed in this action July 23, 1976.

Finally, I note that the issue has previously been litigated in the federal courts, in particular in the case known as New Jersey Hospital Association, et al., v. Anne Klein, Commissioner of Institutions of the State of New Jersey, a suit which, similar to the one at hand, was brought by hospitals furnishing services to Medicaid patients against the reimbursing state, alleging the ineffectiveness of amendments to the state plan, because, among other reasons, the amendments had not been approved by the Department of Health, Education and Welfare.

In commenting on that issue, Judge Barlow of the District of New Jersey, in the case which is designated Civil Action No. 76-64, states at page 5:

"Contrary to the explicit requirements of 42 USC, Section 1396a(a)(13)(D) ... the State of New Jersey has adopted and implemented its ... ceiling rule before receiving the approval of the Secretary of Health, Education and Welfare. Pre-implementation approval also is clearly required by a HEW regulation, 45 CFR, Section 250.30. It would seem clear, then, that the implementation of the ... ceiling without prior HEW approval is not permissible under controlling federal law."

Indeed, Judge Barlow granted summary judgment exclusively, if I analyze the case correctly, on these grounds.

Because I believe the implementation of the amendment to the New York State plan would be invalid in the absence of HEW approval, which has not yet occurred, and because it seems to me that the plaintiffs have established that at least a significant number of members of the class would be damaged irreparably in the sense that their slender reserves of cash would be importantly affected during the pendency of these proceedings, but, above all, because the law simply requires that the amendments must be approved, I believe that the plaintiffs are entitled to judgment on the first cause of action, and that an appropriate injunction should be granted in the circumstances.

I am prepared to stay the effect of that injunction for a period of ten days so that the State can appeal my ruling to the Court of Appeals, which I would expect them to do, considering the seriousness of the subject matter and its effect on the financial problems of the State.

Mr. Imberman reminds me that the State's answer contests the jurisdiction of the Court. I disagree with the State and find that the Court has jurisdiction under 28 USC 1331. It seems to me that the holding in the Catholic Medical Center and other Medicaid cases makes that clear.

I am unprepared to rule at this time as to whether jurisdiction lies under other federal statutes referred to in the complaint.

- - -

O..ICE COPY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----------------------------------x

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other non-profit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid Services rendered to hospital patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

-----------------------------------x

U S DISTRICT COURT
FILED
JUL 30 1976
S. D. OF N.Y.

JUDGMENT

76 Civ. 2027

(Judge Lasker)

This action came on to be heard on Plaintiffs' amended complaint, the answer thereto of the Defendants' Philip L. Toia, Robert P. Whalen, Peter Goldmark and Hugh L. Carey ("State Defendants"), the answer to the complaint of the Defendant David Mathews sued herein as David Matthews, the motion and affidavits in support of and in opposition to the Plaintiffs' motion for a preliminary injunction, and the State Defendants' motion to dismiss the amended complaint; and the Court having heard oral evidence in open court, and all parties hereto having consented to having the trial of the first cause of action on the merits advanced and consolidated with the hearing on Plaintiffs' application for a preliminary injunction pursuant to Rule 65(a)(2) of the Federal Rules of Civil Procedure; and the Court having determined that this action may be maintained as a Class action pursuant to Rule 23 of the Federal Rules of Civil Procedure; and the Court having made findings of fact and conclusions of law as part of its opinion dictated in chambers on July 29, 1976, which was transcribed by the Court Reporter; and it appearing to the Court that the State Defendants are committing acts, and are about to commit acts as set forth in Plaintiffs' amended complaint, and will continue to do so unless restrained by order of this Court, and that immediate and irreparable injury, loss or damage will result to Plaintiffs and the members of the Class as a result; and that Title XIX of the Social Security Act, 42 USC §1396 et seq. ("Medicaid Act") and the regulations thereunder require a state which receives federal funds under the federal Medicaid program to pay hospitals the reasonable cost of in-patient hospital services rendered to Medicaid patients in accordance with methods and standards developed by the State and approved in advance of implementation by the Secretary of Health, Education and Welfare ("Secretary") as part of the state's Plan for Medical Assistance; and that New York State is receiving federal funds under the federal Medicaid program; and that the State Defendants are implementing three regulations - 10 NYCRR §§86.14(b), 86.21(k) and 86.26 in the calculation of Medicaid reimbursement rates for in-patient hospital services rendered on and after January 1, 1976, and that none of these regulations have been approved by the Secretary as part of New York's State Plan for Medical

Assistance ("New York State Plan"); and that the implementation of these regulations has caused and will cause immediate and continuing irreparable injury, loss or damage to Plaintiffs and the members of the Class; and that the State Defendants will continue to implement these three regulations unless enjoined; therefore it is ORDERED AND ADJUDGED:

That so long as New York State participates in the federal Medicaid Program, the State Defendants and their successors, officers, agents, servants and employees are ordered to comply with 42 USC 1396a(a)(13)(D) + 45 CFR 250.30 ~~all federal laws and all rules and regulations of the Secretary applicable to the New York Medicaid program including~~ not in, the requirement of pre-implementation approval by the Secretary of any amendment to the New York State Plan affecting reimbursement for in-patient hospital services and the requirement that hospitals be reimbursed for such services in accordance with the New York State Plan approved by the Secretary pursuant to the Medicaid Act; and

WRC A

That 10 NYCRR §§86.14(b), 86.21(k) and 86.26 and the in-patient Medicaid reimbursement rates promulgated thereunder for Plaintiffs and members of the Class are unlawful; and the State Defendants and their successors, officers, agents, servants and employees are permanently enjoined from applying or attempting to apply said regulations to in-patient hospital reimbursement rates for services rendered by Plaintiffs and members of the Class to Medicaid patients on or

and because the regulations have not been approved by the Secretary until the said [illegible] have been approved by the Secretary M.E.F.

after January 1, 1976; and

That the State Defendants and their successors, officers, agents, servants and employees promptly recompute and pay reimbursement rates for in-patient Medicaid services rendered on and after January 1, 1976 in accordance with the approved New York State Plan and that until such recomputation and payment is complete that they continue to pay ~~those hospitals for whom the 1976 rates promulgated on July 1, 1976 are higher than their 1975 rates at the level of the higher rates, and that they pay those hospitals for whom the 1976 rates promulgated on July 1, 1976 are lower than their 1975 rates at the level of their December 31, 1975 rates.~~

The plaintiffs and the members of the class [illegible] the rates promulgated by the State defendants on July 1, 1976;

The First Cause of Action is hereby severed; M.E.F.

No execution shall issue and no proceeding shall be taken to enforce this judgment until the expiration of ~~10~~ 12 days after its entry.

Dated: New York, New York
July 30, 1976

UNITED STATES DISTRICT JUDGE

JUDGMENT ENTERED - 8/2/76

Raymond F. Burghardt
CLERK

☆ U.S. GOVERNMENT PRINTING OFFICE — 1974-[illegible]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Washington, D. C. 20201

Submit 6 Copies
Y Cif

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

TO: REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION II

TRANSMITTAL NUMBER: 76-43

STATE: New York

PROGRAM IDENTIFICATION: XIX

TYPE OF PLAN MATERIAL (CHECK ONE)
☐ NEW STATE PLAN
☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
☒ AMENDMENT

PROPOSED EFFECTIVE DATE: July 28, 1976

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

FEDERAL REGULATION CITATION
45 CFR 250.30

NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A
Pages 18, 20a

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 4.19-A
Page 18

SUBJECT OF AMENDMENT
Rate Setting - Part 86 of Commissioner of Health's Administrative Rules and Regulations

GOVERNOR'S REVIEW (CHECK ONE)
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL: Philip Toia (Hugh O'Neill)
TYPED NAME: Philip L. Toia
TITLE: Commissioner
DATE: August 2, 1976

RETURN TO:
NYS Department of Social Services
1450 Western Avenue
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED: 3 AUG 1976

DATE APPROVED: 9/16/76

PLAN APPROVED - ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL:

SIGNATURE OF REGIONAL OFFICIAL: Dennis J. Callaghan for
TYPED NAME: William Toby
TITLE: Acting Regional Commissioner
REMARKS

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a medical facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 86.16;

(3) significant increases in the over-all operating costs of a medical facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the Commissioner;

(5) requests for waivers of any provisions of Part 86 for which waivers may be granted by the Commissioner as prescribed in specific sections;

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) In view of the commissioner's responsibility for rates paid by government agencies and article IX-C corporations, and for revisions

(7) requests for relief from the ceiling provisions of section 86.14 of this part. For such relief, a medical facility must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the routine or ancillary ceilings. Such relief shall not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the commissioner.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

(-1-)

---------------------------------------X

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other non-profit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC. and which are reimbursed for Medicaid Services rendered to hospital patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York, and DAVID MATTHEWS, as Secretary of the U. S. Department of Health, Education & Welfare,

Defendants.

---------------------------------------X

NOTICE OF APPEAL

76 Civ. 2027
(Judge Lasker)

SIRS:

PLEASE TAKE NOTICE that defendants Toia, Whalen, Goldmark and Carey hereby appeal to the United States Court of Appeals for the Second Circuit from a judgment of the United States District Court for the Southern District of New York, dated July 30, 1976 and entered in the office of the Clerk of said District Court on August 2, 1976, which declared Regulations 10 NYCRR § 86.14(b), 86.21(k) and 86.26 and the rates for in-patient Medicaid care promulgated thereunder

EXHIBIT III

unlawful because they had not been approved by the defendant Matthews and from each and every part of said judgment.

Dated: New York, New York
August 4, 1976

Yours, etc.,

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for Defendants-
Appellants Toia, Whalen,
Goldsmith and Carey
Office & P.O. Address
Two World Trade Center
New York, New York 10047
Tel. (212) 488-3391

By: Jesse J Fine
JESSE J. FINE
Assistant Attorney General

TO: PROSKAUER, ROSE, GOETZ &
MENDELSOHN
Attorneys for Plaintiffs
300 Park Avenue
New York, N.Y. 10022
(212) 593-9000

UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF NEW YORK
Attorney for Defendant Mathews
One St. Andrews Plaza
New York, N.Y. 10007
(212) 791-1978
Att.: Mr. O'Connor

EXHIBIT III

p. 2

RECORD PRESS, INC., 95 MORTON ST., NEW YORK, N. Y. 10014—(212) 243-5775